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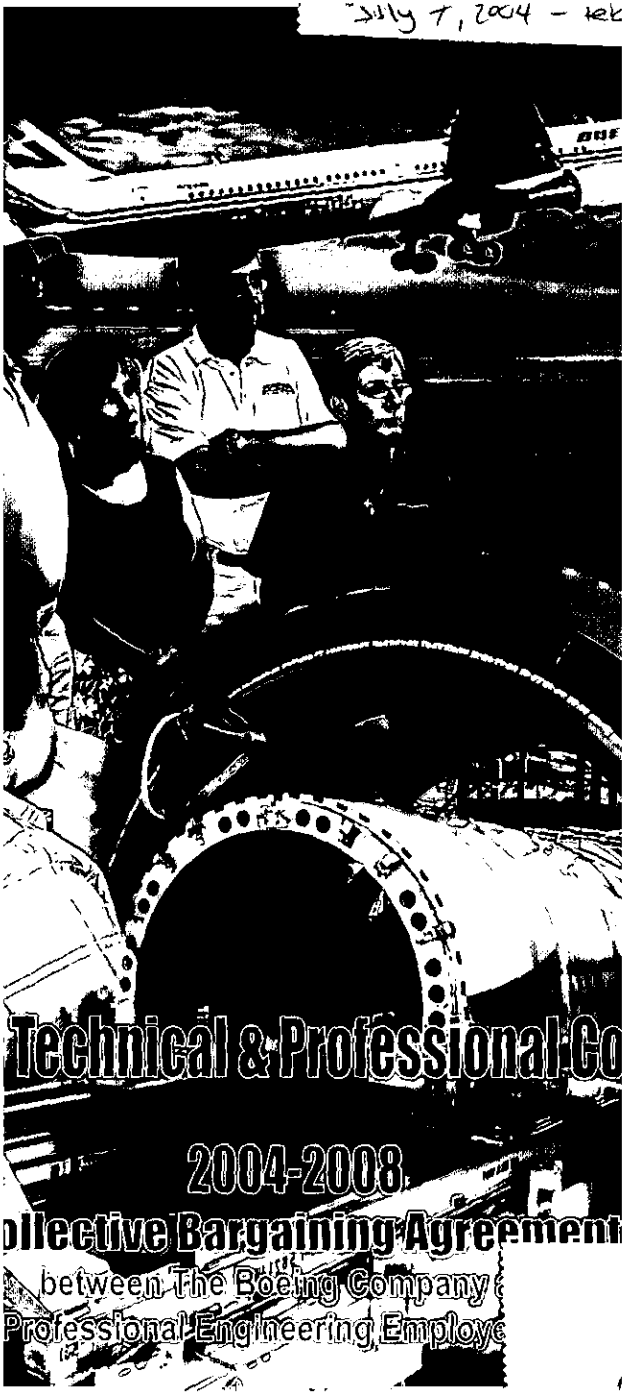

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COLLECTIVE BARGAINING AGREEMENT

between

THE BOEING COMPANY

and

SOCIETY OF PROFESSIONAL ENGINEERING EMPLOYEES IN AEROSPACE – WTPU

THIS AGREEMENT is a reflection of the parties' commitment to these shared principles:

- To maintain a respectful, cooperative relationship; recognizing that the employees are the most valued resource The Boeing Company ('the Company' or 'Boeing') has.
- To work together to further the mutual success of both parties; so that the Company will continue to have a productive, flexible, competitive business with a highly-motivated, skilled and involved workforce while enabling SPEEA to best represent and serve its members.
- To resolve issues to the greatest extent possible through a collaborative process marked by open communication and respect for the employees, the Company and the Union.

ARTICLE 1
RECOGNITION

Section 1.1 Recognition. For the purposes of collective bargaining with respect to rates of pay and other conditions of employment, the Company recognizes the Union as the exclusive bargaining agent for the collective bargaining unit described as follows:

1.1(a) All full-time and regular part-time non-exempt employees and exempt salaried non-engineering employees (except the Occupation/Family codes included below) primarily employed and working at the Company's Wichita, Kansas facilities, but excluding all full-time and regular part-time employees designated as being in the professional unit in the agreement with the Company, the Union and the National Labor Relations Board in the Occupation/Family codes 6ANB, BBAQ, BBAP, 7BTP, BCCK, 7BTN, 7BTR and the 7BTY employed within the SHEA Medical Organization, confidential employees [(1.1(b) below)], managerial employees, guards and supervisors as defined in the National Labor Relations Act, and all other employees.

1.1(b) The Company and the Union agree that a number of employees are excluded from the bargaining unit because of their job functions and/or organizations. The following is a list of categories of work that these employees do and/or the organizations they are in:

1.1(b)(1) Employees who work with confidential personnel information. The people in this group include (a) all individuals working in human resource functions including employment, organizational personnel representatives, compensation and benefits, equal employment opportunity/workforce diversity, staffing and workforce, union relations, people systems and management development; (b) all individuals working in the Employee Assistance Program; (c) all individuals in the Law and Ethics organizations; and (d) all individuals in the Security and Fire protection organization. Not included in this group of confidential employees are those employees who coordinate and provide training programs.

1.1(b)(2) Employees who work with confidential business information. The people in this group include all individuals in the Business Operations, in Internal Audit, in Communications and Public Affairs, in State and Local Government Relations and all Executive Office Administrators. Additionally, certain employees in the Finance Organizations in payroll, payment services, insurance, estimating/pricing, investment analysis, cost management,

3.3(b) The grievance shall be signed by the President of the Union or the designated Company Representative, as the case may be, or their designated representatives. If no settlement is reached within ten (10) workdays from the submission of the grievance to the designated Company Representative or the designated representative of the Union, as the case may be, both shall sign the grievance and indicate it has been discussed and considered by them and that no settlement has been reached and the party responding to the grievance will promptly confirm in writing to the other party the denial of the grievance. Within ten (10) workdays thereafter either party may in writing request that the matter be submitted to an arbiter for a prompt hearing as provided in 3.4 through 3.6.

3.3(c) No matter shall be considered as a grievance under 3.3 unless it is presented to the designated persons within ten (10) workdays after occurrence of the last event on which the grievance is based.

Section 3.4 Selection of Arbiter. In regard to each case that reaches arbitration, the parties will attempt to agree on an arbiter to hear and decide the particular case. If the parties are unable to agree to an arbiter within ten (10) workdays after submission of the written request for arbitration, the provision of 3.5 (Selection of Arbiter-American Arbitration Association) shall apply to the selection of an arbiter.

Section 3.5 Selection of Arbiter – American Arbitration Association. In the event an arbiter is not agreed upon as provided in 3.4, the parties shall jointly request the American Arbitration Association to submit a panel of seven arbiters. Such request shall state the general nature of the case and ask that the nominees be qualified to handle the type of case involved. When notification of the names of the panel of seven arbiters is received, the parties in turn shall have the right to strike a name from the panel until only one name remains. The remaining person shall be the arbiter. The right to strike the first name from the panel shall be determined by lot.

In the event either party is dissatisfied with the credentials of each of the arbiters whose names are contained on the first panel offered by the American Arbitration Association, such party can summarily reject the panel and insist on a second panel. Selection must be made from the second panel.

Section 3.6 Arbitration – Rules of Procedure. Arbitration proceedings shall be in accordance with the following:

3.6(a) The arbiter shall hear and accept pertinent evidence submitted by both parties and shall be empowered to request such data as the arbiter deems pertinent to the grievance and shall render a decision in writing to both parties within sixty (60) days (unless mutually extended) of the completion of the hearing.

3.6(b) The arbiter shall be authorized to rule and issue a decision in writing on the issue presented for arbitration, which decision shall be final and binding on both parties.

3.6(c) The arbiter shall rule only on the basis of information presented in the hearing and shall refuse to receive any information after the hearing except when there is mutual agreement, in the presence of both parties.

3.6(d) Each party to the proceedings may call such witnesses as may be necessary in the order in which their testimony is to be heard. Such testimony shall be limited to the matters set forth in the written statement of the grievance. The arguments of the parties may be supported by oral comment and rebuttal. Either or both parties may submit written briefs within a time period mutually agreed upon. Such arguments of the parties, whether oral or written, shall be confined to and directed at the matters set forth in the grievance.

3.6(e) Each party shall pay any compensation and expenses relating to its own witnesses or representatives.

3.6(f) The Company and the Union shall, by mutual consent, fix the amount of compensation to be paid for the services of the arbiter. The Union or the Company, whichever is ruled against by the arbiter, shall pay the compensation of the arbiter including necessary expenses.

3.6(g) The total cost of the stenographic record, if requested, will be paid by the party requesting it. If the other party also requests a copy, that party will pay one-half of the stenographic costs.

Section 3.7 Binding Effect of Award. All decisions arrived at under the provisions of this Article by the representatives of the Company and the Union, or by the arbiter, shall be final and binding upon both parties, provided that in arriving at such decisions neither of the parties nor the arbiter shall have the authority to alter this Agreement in whole or in part.

Section 3.8 Time Limitation as to Back Pay. Grievance claims regarding retroactive compensation shall be limited to thirty (30) calendar days prior to the written submission of the grievance to Company Representatives, provided; however, that this thirty (30) day limitation may be waived by mutual consent of the parties.

Section 3.9 Extension of Time Limits by Agreement. The time limits set forth in this Article are recognized by the parties as being necessary for prompt resolution of grievances. Reasonable extensions of these time limits may be arranged by mutual written agreement. If a decision is not rendered by the Company within the time limits established for Steps 1 and 2, Section 3.2, the Union may thereupon advance the grievance to the next step. Grievances not presented, or presented and not pursued, within the specified or mutually extended time limits will be considered waived.

Section 3.10 Conferences During Working Hours. All conferences resulting from the application of provisions of this Article shall be held during working hours.

Section 3.11 Signing Grievance Does Not Concede Arbitrable Issue. The signing of any grievance by any employee or representative of either the Company or the Union shall not be construed by either party as a concession or agreement that the grievance constitutes an arbitrable issue or is properly subject to the grievance machinery under the terms of this Article.

Section 3.12 Jurisdictional Disputes. Any disputes where the Union contends either (1) that work performed by represented employees not within the unit described in Article 1 should be performed by employees within the unit, or (2) that represented employees not within the unit described in Article 1 should be included within the unit, shall not be subject to the grievance and arbitration provision of Article 3. Upon the request of the Union, the Company will meet with the Union and discuss the Union's concerns regarding jurisdictional disputes. The Company will consider any information the union wishes to provide before reaching a final decision. This final decision will be neither grievable nor arbitrable. This Section 3.12 shall not apply to such disputes where the Union obtains the written consent of all other interested bargaining representatives to participate in and be bound by the decision of an arbitrator or panel of arbitrators.

ARTICLE 4
EMPLOYEE PERFORMANCE

Section 4.1 Employee Performance Process. The Union and the Company agree that many factors contribute to performance, including but not limited to customer satisfaction, continuous quality improvement, initiative, productivity, technical competence, communication, teamwork, innovation/ creativity, integrity, and leadership. The Employee Performance Process provides a documented means for the employee and manager to assess performance and build employee development plans. The components of the Employee Performance Process are Performance Evaluation and career development. The New Employee Progress Review (NEPR) for new-hire employees is described in Section 4.5.

Section 4.2 Performance Evaluation. Each employee and his or her manager, with the ultimate goal of improving individual and organization performance, will use Performance Evaluation.

Performance Evaluation is designed to promote effective measurement of the value objectives listed below:

- Problem Solving (Judgment)
- Communication
- Technical Skills & Knowledge
- Integrity
- Quality and Productivity
- Customer Satisfaction
- People Working Together (A Diverse and Involved Team)
- Corporate Citizenship
- Enhanced Shareholder Value (Business Knowledge)
- Leadership

Performance Evaluation may also include measurable performance goals tailored to support the business goals of the individual's organization. These performance goals may be specific to the organization, job classification, targets (e.g. Quality, Cost, Delivery, Safety, and Morale), or values.

A weighting methodology and value objective clarification can be applied to all or portions of these measures at the organization, skill team or employee level during the define session. These weighting methodologies and value objectives shall be explained to the employee during Define/Interim/Final PE reviews.

4.2(a) The Performance Evaluation Process consists of three activities: define, interim review and final review. Additional reviews may be conducted as requested.

4.2(a)(1) "Define" consists of communication and documentation of current job responsibilities, value objectives, performance goals, any weighting, and areas of strengths and weaknesses for development, as well as any other subjects relating to performance. Define activities will be completed within forty-five (45) calendar days of the beginning of the annual Performance Evaluation cycle.

4.2(a)(2) "Interim Review(s)" consists of ongoing communication and assessment of current job responsibilities, value objectives, performance goals, any weighting, and areas of strengths and weaknesses for development, as well as any other subjects relating to performance. Each employee shall have at least one interim review during each twelve (12)-month period. In these reviews, progress towards achieving the defined performance and development goals is assessed and summarized. Either the employee or manager may request additional reviews, as appropriate. Interim reviews will normally occur within two (2) weeks of being requested but in no case longer than thirty (30) days.

4.2(a)(3) "Final Review" will be completed by the end of the annual Performance Evaluation cycle. In the final review meeting, overall performance is assessed, summarized, and documented. Employees may attach a list of accomplishments and inputs from customers for discussion during the review period that are in addition to value objectives and performance goals. A copy of the form with the final review summary will be placed in the employee's personnel folder. Supporting data may be retained by the employee and the manager.

4.2(b) It is expected that occasional disagreement over Performance Evaluation content will be resolved at the lowest possible level. A skip-level manager may be involved in the process for this purpose. However, in those few instances where such resolution is not possible, the Union may involve the Major Organization Human Resource Director (or designee).

4.2(c) Performance Evaluation sessions (define, interim and final reviews) shall be scheduled *to maximize their utility in selective salary and retention index decisions. Recommended schedule* is; Define sessions: January - February; Interim sessions: June - July; Final review: December - January.

4.2(d) When an employee transfers to a new group with differing performance goals, a new Performance Evaluation Define session will be scheduled within forty-five (45) days of transfer to the new group.

Section 4.3 Performance Evaluation Form. Forms used in the Performance Evaluation Process shall be the same for all employees in this bargaining unit.

Section 4.4 Career Development. The Union and the Company agree that employees wanting to pursue further career development may use the Performance Development Partnership procedure, PRO-1488, as a tool to work toward that goal.

Section 4.5 New Employee Progress and Performance. In an effort to assist new-hire employees in reaching their full potential, the New Employee Progress Review (NEPR) will be adopted to counsel new *employees to encourage and stimulate job progress and growth. The NEPR can also be used to identify* and constructively address performance deficiencies in a timely manner. The program includes:

- Opportunities for positive, constructive exchange between a manager and a newly-hired employee.
- Performance discussions upon completion of the 30th and 90th calendar days of employment.
- *Performance discussions upon the 180th and 360th calendar days of employment unless the* employee and supervisor have initiated a performance evaluation process.
- Notifying the employee of a performance deficiency.
- Developing a clear and cogent program for the employee to correct a performance deficiency.
- Providing the Union with a copy of the proposed action in a timely manner.

Section 4.6 Process Revisions. Representatives of the Company or Union may ask for a review of the Employee Performance Process during this Agreement. Changes to the Performance Evaluation Process are subject to the mutual agreement of both parties.

ARTICLE 5
VACATION PLAN

Section 5.1 General. *Reasonable time away from the job is conducive to good health and well being* and is considered in the best interest of the employee and the Company. Each employee should have the opportunity to schedule and take vacation each year and thereby use their vacation credits, allowing adequate staffing for Company operations.

Section 5.2 Accumulation of Vacation.

5.2(a) Vacation credits are accrued daily and awarded weekly, with credits increasing on the basis of established increments as follows:

Company Service	Annual Vacation
1 thru 4 years	80 hours
5 thru 9 years	96 hours
10 and 11 years	120 hours
12 and 13 years	128 hours
14 and 15 years	136 hours
16 and 17 years	144 hours
18 years or more	160 hours

Company service date will be used to determine the credits to be awarded. Vacation credits may accumulate to a maximum of two years of credit (as determined from above schedule). No additional vacation credits will be accrued until the number of credits in the account drops below the two-year maximum.

Vacation credits will not be accrued in excess of ninety calendar days on a leave of absence.

5.2(b) Part-time employees are awarded vacation credits in accordance with the above schedule on a pro-rata basis. Vacation credits will be pro-rated based on hours paid (excluding overtime and short-term disability leave payments).

5.2(c) Vacation accounts will be maintained to the nearest tenth of an hour unit.

5.2(d) Eligibility dates and accumulated vacation credits established prior to this agreement will not be changed as a result of this agreement.

Section 5.3 Use of Vacation Credits.

5.3(a) Subject to management approval based on Company work schedule requirements, previously awarded vacation credits may be used by the employee without limit. Management will encourage employee use of vacation for time off within the period when credits are available. Use of vacation at times convenient to the employee will be arranged to the extent permitted by Company work schedule requirements.

5.3(b) Vacations are to be taken as time off and there will be no pay in lieu of time off.

5.3(c) Generally, vacation credits are to be used in units equal to the scheduled hours in the employee's normal workday; however, non-exempt employees may use vacation credits in lesser amounts to permit a partial day absence. Also, in cases when sick leave credits are exhausted, non-exempt employees may charge a partial day of absence for sick leave against vacation credits in any amount up to the scheduled hours in the employee's normal workday. Exempt employees must take vacation in whole day increments.

5.3(d) Part-time employees normally will use vacation credits in amounts comparable to their part-time work schedules. However, subject to the scheduling requirements of his or her organization, a part-time employee may request and receive vacation in eight-hour increments.

5.3(e) Holidays occurring while an employee is on vacation are not deducted from vacation credits.

5.3(f) Payment for vacations will be made at the employee's base rate in effect at the time vacation is taken plus, if applicable, any supplement to the base rate approved by the Company for inclusion in vacation pay.

5.3(g) An employee on leave of absence is eligible to use vacation credits.

Section 5.4 Vacation Payment on Termination. An employee who terminates for any reason will be paid for all unused credits in his or her vacation account and all accrued vacation through the last day worked.

Section 5.5 Vacation Credits When Payroll Is Changed. In all cases involving the transfer of an employee from one payroll to another, the provisions of the Company's procedures pertaining to vacations, as may be revised from time-to-time by the Company, shall be applicable.

ARTICLE 6
SICK LEAVE

Section 6.1 Establishment of Initial Eligibility for Sick Leave.

6.1(a) Employees classified on a salaried payroll become eligible for sick leave upon completion of one (1) month continuous active service with the Company.

6.1(b) When the continuity of employment is broken other than by layoff or termination to enter military service, an employee must begin with the date of reemployment to accumulate one (1) month continuous active service with the Company before being eligible for sick leave.

Section 6.2 Accumulation of Sick Leave.

6.2(a) On the first workday following completion of one (1) month of continuous active service, a full-time employee will be credited with eight (8) hours sick leave. Thereafter, he or she will accumulate eight (8) hours sick leave for each month of active service to a maximum of eighty (80) hours during the first and each succeeding year of service. For part-time employees, sick leave credits will be accumulated in the proportion that the hours worked bear to full-time hours, rounded to the nearest one-tenth (1/10) hour unit.

6.2(b) In all cases involving the transfer of an employee from one payroll to another, the provisions of the Company's procedures pertaining to sick leave, as may be revised from time to time by the Company, shall be applicable.

6.2(c) No sick leave credit will be accumulated during periods on layoff or for absence in excess of the first ninety (90) calendar days on a leave of absence. Such absence from the active payroll will reduce the monthly sick leave award, if applicable, in the proportion of 1/30th of eight hours for each calendar day of absence during the month, or a comparable proportionate reduction if a part-time employee, rounded to the nearest tenth of an hour.

6.2(d) Eligibility dates and accumulated sick leave credits established prior to this Agreement will not be changed as a result of this Agreement.

Section 6.3 Use of Sick Leave.

6.3(a) Sick leave credits are to be used only in the event of absence due to the following causes: (a) illness of employee, including physical incapacity of a female employee due to her pregnancy; (b) illness or death in the family (requiring the employee's presence); and (c) medical or dental appointment which can be scheduled only during the working hours. Non-exempt employees may use sick leave in any increments, but exempt employees shall use NONIND for usage of less than a full day.

6.3(b) Sick leave payments will be at the employee's base rate in effect at the time of his or her absence plus; if applicable, any supplement to the base rate approved by the Company for inclusion in sick leave pay.

6.3(c) Sick leave hours will be used from sick leave hours most recently credited.

6.3(d) Notwithstanding 6.3(a), sick leave credits may be used by an employee on leave of absence.

deemed practicable by the Company, surpluses will be resolved by placing individuals in other assignments.

8.1(b) Job Classification and SMC of Record Shall Prevail. Notwithstanding any challenges concerning job classification and SMC by individual employees or the Union under Article 3 or Article 22, employee reassignments or layoffs effected under the provisions of this Article shall be based upon each employee's job classification and SMC of record at the time of such action. Individual employee or Union contentions that a re-assignment or layoff is inappropriate, inasmuch as the employee's assigned job classification and SMC prior to or at the time of such re-assignment or layoff is or was alleged to be inappropriate, are specifically excluded from the grievance procedure described in Article 3, and shall afford no basis for any claim on the part of the individual employee or Union that such re-assignment or layoff should be voided or set aside.

Section 8.2 Procedure Relating to the Filling of Positions.

8.2(a) The parties are agreed that it is in their mutual interest to assure that favorable promotional and retention consideration is granted to those individuals who are best able to maintain or improve the efficiency of the Company, further its progress and contribute to the successful accomplishment of current and future business. Accordingly, in the filling of positions, particular attention will be given to the development, advancement and retention of the existing workforce.

8.2(b) Re-assignments and transfers of the following kinds may be made by the Company without regard to the provisions of 8.2(e). Positions so filled shall not be regarded as open positions.

8.2(b)(1) Re-assignments of surplus employees and surplus individuals from management, engineering, or other salaried payrolls.

8.2(b)(2) Non-promotional reassignments of non-surplus employees (as, for example, to staff new programs or to avoid surpluses).

8.2(b)(3) Return of employees from layoff status or from leaves of absence.

8.2(b)(4) Transfers into the bargaining unit of individuals who at some previous time were assigned to Job Classification and Skills Management Codes currently within the bargaining unit.

8.2(c) An "in-place" promotion is the promotion of an employee to a higher level within the same Job Classification and Skills Management Code. This promotion results from expansion of the employee's own work assignment and is not for the purpose of filling a position vacated by another employee. Such an in-place promotion does not constitute the filling of a position within the meaning of 8.2, and the Company may make such in-place promotions without limitations.

8.2(d) All vacant positions other than those filled as described in 8.2(b) and 8.2(c) shall be designated as open positions.

8.2(e) The Company will seek candidates from within the existing workforce for all positions that are designated by the Company as open positions. Employees on the active payroll who have been declared surplus and/or who have been previously downgraded shall have priority rights to open positions as described in 8.2(e)(1) and 8.2(e)(2), respectively. For open positions remaining after the provisions of 8.2(e)(1) and 8.2(e)(2) have been met, other candidates shall receive consideration as described in 8.2(e)(3).

8.2(e)(1) If an open position occurs for a Job Classification and Skills Management Code in which layoffs are authorized, an employee already assigned to that Skills Management Code shall be selected for the open position.

8.2(e)(2) If, after application of 8.2(e)(1), the open position still exists, first consideration shall be given to an employee who meets all the following conditions:

8.2(e)(2)a Was, within six (6) years preceding the date on which the open position is designated, while on the active payroll, downgraded for other than performance reasons as specified in 22.4(b) from the same Job Classification and Skills Management Code as the open position, or from a higher level of that Job Classification and Skills Management Code, or from a directly-related management, engineering, or other payroll position.

8.2(e)(2)b Has not declined a Company offer of return to the Job Classification and Skills Management Code from which downgraded.

8.2(e)(3) If the open position still exists following application of 8.2(e)(1) and 8.2(e)(2), other candidates will receive consideration in the following order:

(a) Individuals on file for recall as described in 8.4(b) and candidates who make timely application for the open position through the Company's Employee Requested Transfer system.

(b) Others.

The Company will select for the open position whichever of the considered candidates it determines will best achieve the purposes set forth in 8.2(a).

8.2(f) Employee Requests for Transfer. The Company will maintain an environment in which employees can make known their interest in transferring to other positions for which they are qualified to perform and which may satisfy their personal needs. A job posting and transfer process will be maintained which will allow employees, without fear of reprisal, to make application for transfer and receive consideration as a candidate for open positions for which they are qualified. All employees, including those involved in surpluses, shall have full access to the Jobs@Boeing process. The Company will provide the Union with a copy of the request for transfer procedure and any changes thereto.

Section 8.3 Retention System and Re-deployment Procedure.

8.3(a) Objective. The general objective of the procedure stated in this 8.3 is to provide for the accomplishment of layoffs for business reasons, to the end that insofar as practicable the layoffs will be made equitably, expeditiously and economically, and at the same time will result in retention on the payroll of those employees regarded by management as comprising the workforce that is best able to maintain or improve the efficiency of the Company, further its progress and success and contribute to the successful accomplishment of the Company's current and future business. The occurrence and existence of any condition necessitating a layoff, and the number of employees involved will be determined exclusively by the Company. Following such determination, the Company will notify the Union of the anticipated layoff and, the affected retention groups and numbers of employees apt to be affected. Affected employees will be given two (2) weeks' notice prior to layoff wherever practicable, and will receive consideration for open positions in accordance with 8.2(e).

8.3(b) Retention Index. Management will assign a retention rating to each employee to whom this Article applies with the basic objective of identifying those employees best able to maintain or improve the efficiency of the Company, further its progress and success and contribute to the successful accomplishment of the Company's current and future business as identified in the employee's Performance Evaluation Process. Consistent with this objective, Management will take into account each employee's competence, diligence and demonstrated usable capabilities based upon the employee's current performance and a review of the employee's previous performance. Employees on part-time work schedules as defined in 11.4 will be retention rated with employees on full-time work

schedules. Length of company service will be a positive factor to the extent that the experience so gained continues to be reflected in increased capability.

8.3(b)(1) Frequency. A retention index review will be conducted no sooner than four (4) months nor longer than twelve (12) months from the prior periodic retention index review. In each review, the Company will group employees for retention purposes and designate the retention rating of each employee in the group as R1, R2 or R3.

8.3(b)(2) Retention Index Group Make-up. Management will determine retention index groups taking into account skill teams, Major Organizations, Principal Subordinate Organizations, Occupation Code, Job Family, Skills Management Code and Level. The Union will be provided a listing of the Retention Index Groups and as groups are formed or changed, the Union may make suggestions to the Company on how to improve the groupings. Whenever possible, retention groups will be defined in such a way as to group employees in groups of at least ten (10) who are performing the same type of work. In a Retention Index Group, the same-level employees should be able to perform each other's work and higher-level employees should be able to perform lower-level work. Exempt and non-exempt employees will not be in the same retention group.

8.3(b)(3) Review Process. The Company will determine the retention rating of each employee, the members of management who will participate in retention index reviews, the retention index groups to be used, the timing, and the other details of such reviews. Members of management participating in the reviews will be instructed by the Company to make retention index assignments with care, giving full consideration to the objective stated in 8.3(a) and 8.3(b). Such instructions will stress that retention rating is to be assigned without regard to potential adjustments for Company service as provided for in 8.3(b)(5). It is recognized that any practicable process of assigning a retention rating to each employee cannot be completely free of error as to method used or as to resulting retention rating, taking into account: the large numbers of employees, Skills Management Code, organizations and requirements involved; the fact that numerous management representatives necessarily must participate in the process; and that many of the factors which must be dealt with are intangible in nature. The review process shall not be subject to the grievance and arbitration procedure; however, an employee may appeal the employee's assigned retention rating as provided in 8.3(b)(7).

8.3(b)(4) Distribution. Each employee will be assigned a retention rating such that, as nearly as is mathematically practicable, and except as provided in 8.3(b)(8), the retention index distribution for retention groupings within each retention index group is R1 - 38 to 42%, R2 - 38 to 42%, and R3 - 18 to 22%.

Since personnel transactions will occur subsequent to each periodic review, it shall not be necessary to maintain this distribution during intervals between periodic reviews.

8.3(b)(5) Adjustments for Company Service. As a part of each periodic retention index review, and immediately following completion of the distribution procedure set forth in 8.3(b)(4), the retention rating of certain employees will be adjusted in compliance with the following:

Employees with twenty (20) or more years of Company service whose assigned retention rating is R3 will be given an adjusted retention rating of R2. Employees with thirty (30) or more years of Company service will have their retention rating raised one level if their retention rating is R3 or R2. Such adjustments will be reflected in the written notification to each employee described in 8.3(b)(6). (Employees who reach the aforementioned Company service dates between periodic retention index reviews will receive an adjusted retention rating accordingly.) Notwithstanding the above adjustments, management shall be obligated to protect employees with an unadjusted R2 or R1 retention rating from being laid off ahead of employees with an adjusted R2 or R1 retention rating in the same retention group.

The adjusted retention rating shall apply to the layoff sequence described in 8.3(d). Employees designated pursuant to the process described in 8.5 below may not be eligible for retention service adjustments. Such employees may appeal their R3 using the process described in 8.3(b)(7).

8.3(b)(6) Employee Notification. Following each periodic retention index review, the Company will provide each employee with a written notification of the employee's retention rating prior to the effective date, except where such is made impracticable due to the unavailability of the employee or the supervisor occasioned by vacations, travel assignments, etc. In such circumstance the notification will be given as soon as practicable. In addition, management will discuss the new retention rating with employees. The written notification will contain:

8.3(b)(6)a The employee's Job Classification,

8.3(b)(6)b The employee's retention rating prior to and following any adjustment under 8.3(b)(5),

8.3(b)(6)c The number of employees in each of the three retention index categories [as adjusted under 8.3(b)(5)], within the employee's retention index group,

8.3(b)(6)d The effective date, and

8.3(b)(6)e A description of the jobs and levels included in the retention group.

8.3(b)(7) Retention Index Appeals. An employee who feels the assigned retention rating is inappropriate may at any time discuss the matter with his or her immediate supervisor. If within 30 calendar days following notification of the assigned retention rating the employee elects to appeal the rating, and discussion with the immediate supervisor has not resolved the employee's concern, certain ratings may be appealed for further review as provided below:

8.3(b)(7)a The retention rating represents a one or more position drop from the previous rating, and it is substantiated that the drop is not due to the effect of workforce reduction and/or consolidation of retention index groups.

8.3(b)(7)b The employee has been assigned a retention rating of R3 during four or more consecutive retention reviews.

8.3(b)(7)c The employee so affected will address his or her concerns in writing to the Union setting forth the basis for such appeal.

8.3(b)(7)d If the Union believes the employee's appeal warrants further review, the Union will notify the Workforce Administration Manager of the applicable Major Organization within ten (10) workdays of receipt of the employee's appeal.

8.3(b)(7)e Within ten (10) workdays following such notice, the Major Organization Workforce Administration Manager (or designee who shall not have been previously involved in the assignment or appeal of the retention rating), the appropriate Human Resources Representative and a Union Representative will meet to resolve the appeal. Pertinent information may be obtained from the employee, the immediate supervisor and/or the Management Totem Captain.

8.3(b)(7)f The Workforce Skill Team Strategist, the Labor Relations Representative, and the Union Representative will resolve the appeal by majority decision at the meeting or within five (5) workdays thereafter. In the event the Union considers the decision to be inappropriate to the facts of the case, the Union may advance its appeal to the Site Workforce Manager. After this review of the matter by the Site Workforce Manager, unresolved appeals may be advanced

to the Site Manager of Labor Relations who shall resolve the appeal. Such resolution by majority decision or by decision of the Site Workforce Manager or the Site Manager of Labor Relations, as the case may be, will be final and binding and will conclude the appeal process.

8.3(b)(7)g If the result of an appeal over a two position drop in retention level is in favor of the employee, one of the following options may be selected as determined by Company and Union representatives:

(1) Restoration to the previous retention rating of R1, or

(2) Modification of the assigned retention rating to R2.

8.3(b)(8) Summer Interns and Co-Ops. Summer Interns and Co-Ops will not be included in or subject to the periodic retention index review.

8.3(c) Out-of-Sequence Retention Rating.

8.3(c)(1) The retention rating of an employee who is reclassified between periodic retention index reviews will be sustained or revised, depending on whether the employee moves between retention groups that are sequenced with regard to levels.

8.3(c)(1)a With downward movement between sequenced retention groups, the employee will become an R1 until the next retention index review or until management reassigns a retention.

8.3(c)(1)b With an upward movement between sequenced retention groups, the employee will automatically receive a retention rating of R3 until the next retention index review or until management reassigns a retention.

8.3(c)(1)c When no level sequencing between groups is involved, the employee will retain the same retention rating as before the reclassification until the next retention index review or until management reassigns a retention.

8.3(c)(2) An employee who returns from leave of absence between periodic retention index reviews shall retain the same retention rating as before the leave of absence until management assigns the employee a different retention rating and so notifies the employee.

8.3(c)(3) An individual who enters the bargaining unit between periodic retention index reviews shall automatically be assigned retention rating R3 until management assigns the employee a different retention rating and so notifies the employee.

8.3(c)(4) An individual who returns from layoff shall be assigned the retention rating of record at the time of layoff, providing there has not been a retention index review during the layoff period. The individual will automatically be assigned retention rating R3 if a retention index review has been conducted during the layoff period.

8.3(c)(5) The out-of-sequence retention rating assigned under the provisions of 8.3(c)(1) through 8.3(c)(4) will be reaffirmed or superseded by the retention rating assigned during the next periodic retention index review.

8.3(d) Re-deployment Procedures.

8.3(d)(1) Application. When a workforce reduction is determined by management to be necessary within one or more Retention Index Groups, management will follow the applicable provisions of Article 9 and designate for layoff the required number of employees within

such Retention Index Groups, beginning with the lowest retention index. Exceptions to the designation for layoff may be made by the Company where it desires to retain a maximum of 10% of employees who are retention index R3, 10% of employees who are retention index R2, and 10% of employees who are retention index R1 within an affected Retention Index Group as of the time of the most recent retention index review. Exceptions will be identified in writing to the Union representative.

8.3(d)(1)a One (1) employee may be subject to the 10% exception if there are one (1) to fourteen (14) employees in the retention index group;

8.3(d)(1)b Two (2) employees may be subject to the 10% exception if there are fifteen (15) to twenty-four (24) employees in the retention index group;

8.3(d)(1)c Three (3) employees may be subject to the 10% exception if there are twenty-five (25) to thirty-four (34) employees in the retention index group;

8.3(d)(1)d Higher numbered retention index groups may be rounded similarly.

8.3(d)(2) Employees designated for layoff in a retention group that is sequenced by levels with a group that has lower levels and which is populated will be given consideration for downgrade in lieu of layoff.

8.3(d)(3) Employees on travel status may not be laid off while on such status. Such employees shall not be counted among or reduce the number of exceptions permitted by the provisions of 8.3 nor shall their retention prevent the layoff or downgrade of employees with a higher retention index who are otherwise subject to such action.

8.3(d)(4) Employees selected by management to participate in a program of formal training in a field outside their current Skills Management Code, which training is conducted or approved by the Company, and employees who at management's request transfer from one major functional area to another for a Company-sponsored skill transition and retraining program will be assigned a unique job code upon entering the training program or upon transfer to the new functional area respectively. The trainee shall retain this unique code for a period of six (6) months following completion of training or transfer to the new functional area, as the case may be, in order to allow time for the trainee to demonstrate his or her adaptability to the new assignment. During the period in which the trainee is assigned the unique code, he or she will retain the retention index held at the time of assignment to the unique code. In the event a surplus is declared in the trainee's new assignment and if the trainee's retention index would cause him or her to be an individual surplused, the trainee will be returned for assignment to an area under his or her last held regular assigned Skills Management Code and the retention index of record.

8.3(d)(5) Employees laid off after refusing less than equivalent job offers made as a result of re-deployment activities will be considered involuntary layoffs and will be eligible for layoff benefits as defined in Article 21.

8.3(d)(6) During periods of surplus activity, the Company may make available programs intended to mitigate the impact of layoffs. The Company will advise the Union of these programs and their availability.

8.3(d)(7) The Company and the Union agree that, any provision in the parties' Collective Bargaining Agreements to the contrary notwithstanding, an employee may request that he or she be voluntarily laid off. If the request is approved by management, the employee will be coded as a layoff and will be regarded for all Company purposes as a laid off employee, except for purposes of layoff benefits under Article 21. The Union will be advised of all employees approved for voluntary layoff.

8.3(e) Exceptions to Foregoing Procedures.

8.3(e)(1) The Company may lay off employees without regard to the provisions of the layoff procedures set forth in 8.3, provided the number of such layoffs per month does not exceed 0.25% (one quarter of one percent) of the total number of employees employed in the bargaining unit on the first day of that month.

8.3(e)(2) In instances where in the opinion of the Company the layoff procedures set forth in 8.3 do not achieve the objectives stated in 8.3(a), exceptions thereto, without any limitation as to the number, may be made when approved by the Chief Executive Officer or designated representative. It will be the responsibility of any supervisor who recommends such an exception to prepare and transmit through the line organization to the Major Organization Manager, and then to the Office of the Chief Executive Officer or designated representative, a detailed report of the proposed exception(s) and the reasons therefore. An explanation, prior to implementation, will be provided to the Union.

Section 8.4 Layoff Status and Return to Active Employment.

8.4(a) Maintenance of Layoff Status.

8.4(a)(1) Each employee laid off under the provisions of this Article will remain on layoff status for a total period of three years from the date the layoff was effective, subject to 8.4(a)(2).

8.4(a)(2) An employee shall remain on layoff status in accordance with 8.4(a)(1), provided he or she does not:

8.4(a)(2)a Fail to respond to a formal offer from the Company of a job within ten (10) workdays after it is extended or by such later date as may be stipulated by the Company, or

8.4(a)(2)b Refuse a formal offer from the Company for a full-time job within the bargaining unit or in the same labor market area from which laid off, for which the salary or level offered is equal to or greater than the employee's salary at the time of layoff plus the inflation adjustment in effect at the time of layoff, or

8.4(a)(2)c Fail to report to work within ten (10) workdays following acceptance of a formal Company offer or on such later date as may be stipulated in the Company offer, or

8.4(a)(2)d Elect retirement under the Company Retirement Plan thereby removing themselves permanently from layoff status.

8.4(a)(3) Employees removed from layoff status for any reason other than retirement or expiration of the three (3)-year period following layoff will be notified in writing of such removal, and the reasons therefore, by the Company.

8.4(a)(4) Laid-off employees who are prevented from meeting the conditions described in 8.4(a)(2)a, 8.4(a)(2)b or 8.4(a)(2)c solely due to medical disability, verified to the Company's satisfaction by their personal physician, shall upon request be granted a waiver for the missed requirement(s).

8.4(b) Return to Active Employment.

8.4(b)(1) It is a mutual objective of the Company and the Union that laid-off employees who have not been determined ineligible under 8.4(b)(3), 21.3(a), or 8.5 be recalled to active employment, and a mutual desire that such recall into the Major Organization from which the employee was laid off be offered in approximate reverse order of layoff. Accordingly, employees on file for recall pursuant to 8.4(b)(4) will be offered return to active employment within the applicable Retention Group in approximate reverse order of layoff, prior to workforce additions from sources external to the Company, subject to the following limitations:

8.4(b)(1)a Nothing in 8.4 will preclude the Company from hiring from sources outside the Company when projected requirements exceed the number of employees in applicable Skills Management Codes on file pursuant to 8.4(b)(4) who are eligible for an offer of recall.

8.4(b)(1)b In making recall and hiring decisions, the Company will review the specific qualifications of individuals on the basis of product familiarity, specialized experience or education, customer requirements, and the need to achieve the most efficient and accurate match of individual capabilities to job requirements. Consequently, not all Company decisions relating to recall and hiring can promote the mutual objective and desire stated above. Such decisions will not be subject to Article 3.

8.4(b)(2) If a Major Organization has an opening for a position or positions and the Major Organization has no people who are eligible to return to active employment under 8.4(b), but there are persons who are eligible for return to active employment under 8.4(b) in a different Major Organization or in a different Retention Group, in the same Job Classification and the same Skills Management Code, then those eligible people should be considered for the position or positions before the job is posted externally. If no one is selected for the opening from the list of eligible persons from another Major Organization or different Retention Group, then approval must be obtained from the appropriate site-wide skill team before the position is advertised externally.

8.4(b)(3) The Company periodically will review with the Union the operation of 8.4(b)(1) in order to facilitate achievement of the mutual objective and desire stated above.

8.4(b)(4) Prior to layoff, the Company will review those employees holding an R3 retention index to determine eligibility for re-employment consideration under 8.4(b)(1). The review will be limited to those employees for whom there is supporting documentation of performance deficiencies. The review will be performed by the cognizant management for the employee's Skills Management Code. Based on the review, the employee will be advised no later than the time the layoff notice is issued as to his or her eligibility for re-employment consideration under 8.4(b)(1). An employee determined ineligible may appeal such determination to the cognizant captain. If the appeal does not resolve the matter, the employee may then file a grievance in accordance with Article 3. Such grievance shall be limited to the first three (3) steps of the grievance procedure and shall not be subject to arbitration.

8.4(b)(5) At the time of layoff, the Company automatically will place in the file for priority consideration return to active employment the names of all laid-off employees. The Company will maintain a list of the names of all laid-off employees except those determined ineligible under 8.4(b)(4), those who have received layoff benefits as a lump sum under 21.3(a), and those identified in 8.5. In order to maintain such recall status, the employee must keep the Company informed of his or her interest in returning to active employment by submitting a letter so stating. The employee must register by letter once each consecutive calendar half-year period (January through June; July through December) during the three (3)-year period from the date of layoff. Registration letters must be received within forty-five (45) days prior to the expiration of the current half-year period and must contain the individual's name, social security number, address, and telephone number. Individuals who do not properly register in each calendar period will be removed from the priority consideration eligibility list. Failure to register properly will result in priority consideration eligibility being revoked for the remainder of the three (3)-year period. Eligible employees on file for return to active employment are subject to the provisions of 8.4(a).

8.4(b)(6) If any employee on layoff status disputes his or her recall status as reflected in Company records, Company records shall prevail unless rebutted by either:

(1) a Company receipt, or

(2) a properly addressed U.S. Postal Service return receipt evidencing filing of the registration letter during the calendar period in question.

8.4(c) Salary and Level of Returning Laid-Off Employees. *Company offers to laid-off employees for return to active employment in the same area will be extended at whatever salary and level is deemed by management to be appropriate. Rejection of a formal Company offer for a position outside the bargaining unit or a labor market area other than from which laid off, or at a salary lower than the employee's salary at time of layoff, or a level lower than the level from which laid off, will not be cause for removal from layoff status.*

8.4(d) Employees who remain on layoff status for the full period specified in 8.4(a)(1) will, for a period up to six (6) years from the date the layoff was effective, remain eligible for certain additional retirement benefits as specified in the Retirement Plan.

8.4(e) The Company will maintain a record of all laid-off employees who are on layoff status under the above provisions.

Section 8.5 Designated Employees.

8.5(a) A mutually agreed upon process has been developed and implemented for the purpose of identifying employees who, while not subject to 8.4(b)(4), either will be declared ineligible for first consideration recall rights or will not receive retention service adjustment or both. This process includes the following elements:

8.5(a)(1) Designated employees will be identified as part of the retention indexing process and advised in writing that, in the event of layoff during the period of time between retention indexes, either they will have no first consideration recall rights or will not receive a retention service adjustment or both.

8.5(a)(2) *Designated employees must have an assigned R3 retention index rating.*

8.5(a)(3) *Designated employees will be identified by skill teams.*

8.5(a)(4) Designated employees who have one (1) full year of service and who elect to receive income continuation benefits under 21.3(b) will nevertheless be ineligible for first consideration recall rights.

8.5(b) Employees who have been so designated will be provided with an Employee Improvement Action Plan which will identify the specific conditions leading to the designation and improvements necessary to avoid such designations in the future. Management and the employee will have on-going discussions about the employee's progress in achieving the objectives outlined in the action plan. The Company will promptly notify the Union of the identities of designated employees. The identification of designated employees shall not be subject to Article 3; however, designated employees may appeal the designation regardless of their previous retention index rating in accordance with 8.3(b)(7). Designations pursuant to this section will remain in effect until the next scheduled retention review exercise or until the employee satisfactorily completes the Improvement Action Plan and has been removed from designation.

Section 8.6 Temporary Recall.

8.6(a) The parties acknowledge that Article 9 limits the use of contract personnel during workforce reductions or when employees are on active recall status. The parties acknowledge further that occasionally situations arise when short-term assignments require additional staffing. In the past, the Company has contracted those work packages to non-Boeing entities. The Company in its sole discretion has from time to time preferred to have this work performed by employees on active layoff status. In recognition of the fact that the work under discussion involves short-term assignments, the parties agree to the implementation of the process described immediately below.

8.6(b) *The process shall be known as Temporary Recall and shall be defined as the temporary re-employment of individuals on active layoff status (hereinafter "employees").*

8.6(c) Temporary Recall assignments may be designated for specific programs or projects whose normal maximum will be six (6) months. Assignments will normally be full time (average 80 hours in a pay period).

8.6(d) The Company will determine which employees will be offered Temporary Recall assignments. Temporary Recall will be strictly voluntary on the part of the employee. Refusing to consider an employee for Temporary Recall or an employee's rejection of an offer of Temporary Recall will not affect the employee's active layoff status.

8.6(e) Temporarily-recalled employees will receive the same salary they were receiving prior to layoff, adjusted for any general wage increases implemented between the date of their original layoff and temporary recall.

8.6(f) If the temporarily-recalled employee begins within one (1) year of the original layoff effective date, eligibility for coverage for medical/dental insurance, life insurance, accidental death and dismemberment insurance, business travel accident insurance, long-term and short-term disability insurance, and voluntary personal accident insurance begins on the first day of the month following the month in which the re-employment commences. If the temporarily-recalled employee begins at least one (1) year after the original layoff effective date, eligibility for coverage for such benefits begins the first day of the month following one (1) full calendar month of continuous employment.

8.6(g) With regard to the Retirement Plan, unused sick leave, and vacation, employees on Temporary Recall will be set up in the system based on their respective layoff/recall circumstances. This will include the reactivation of unused but earned credits and the generation of future benefits consistent with standard policies. Voluntary Investment Plan contributions may be resumed, beginning on the first of the month following recall.

8.6(h) Company service will be earned beginning the first day back on the active payroll.

8.6(i) Active layoff status will not be interrupted. Filing requirements once during each half-year for first consideration recall status will remain.

8.6(j) Employees on Temporary Recall will not receive a retention index based on Temporary Recall assignments.

8.6(k) Employees on Temporary Recall will generate funds for a selective adjustment exercise if they meet contractual criteria.

8.6(l) Employees on Temporary Recall will not be eligible for layoff benefits when their Temporary Recall assignment ends.

8.6(m) The Company is in the process of developing a policy on temporary recalls. Upon implementation of that policy the terms and conditions of the policy will govern employees on temporary recall and supersede this Section. The Company will review the draft policy with the Union prior to implementation and will consider its comments when forming the contents of the policy.

Section 8.7 General Provisions.

8.7(a) Compensable Injuries. Any employee who has been wholly or partially incapacitated for that employee's regular work by compensable injury or compensable occupational disease while in the employ of the Company may, while so incapacitated, be employed in work which the employee can do without regard to the provisions of this Agreement. The Union shall be notified of persons to whom this waiver applies and the effective dates of such waiver.

8.7(b) Veterans. The Company and the Union, recognizing that the re-employment rights of employees entering or inducted into the Armed Forces of the United States are the subject matter of

legislation, agree that nothing contained in this Agreement will preclude the Company from re-employing such employees in compliance with provisions of applicable laws.

8.7(c) Transfer Return Rights. An employee who is transferred by the Company from the bargaining unit described in Article 1 of this Agreement to another SPEEA-represented bargaining unit, and at the time of such transfer is accorded return rights by the Company in writing, will not be laid off while assigned at such other unit, but will be transferred back to the original unit in accordance with the return rights previously accorded by the Company. An exception will be made if the employee elects to be laid off in which case the employee will waive transfer return rights.

8.7(d) Hiring of Employees on Part-Time Work Schedule. The Company will not hire new employees into the bargaining unit on part-time work schedules and will not normally approve part-time work schedules for employees with less than two (2) years of Company service; provided, however, that the Company may rehire retirees on part-time schedules. Approval of part-time work schedules may be revoked at any time at management's discretion.

ARTICLE 9
CONTRACT PERSONNEL

Section 9.1 Purpose. The Company and the Union recognize that Contract personnel are a practical source of skilled temporary labor that allows the Company to acquire skilled professional and technical support in a timely manner. The Company and Union recognize that requirements for experienced Contract personnel must be balanced with the need to build and maintain the Boeing experience base and to support our mutual objective of workforce stabilization by minimizing employee layoffs.

Section 9.2 Definition. The term Contract personnel refers to temporary personnel supplied by another business entity to perform work on Company premises under the daily control and supervision of Company management. The business entities that provide Contract personnel normally are in the business of providing temporary services (such as temporary employment agencies and staffing firms). Sources of Contract personnel may also include businesses in the aerospace or related fields that make their personnel available for temporary labor (so called 'industry assist' arrangements). Excluded from the definition of Contract personnel are consultants and their employees and employees of subcontractors or vendors.

Section 9.3 Procedures and Limitations.

9.3(a) The Company shall notify the Union of the basis for the need, the approximate number of Contract personnel required and the Skills Management Codes normally held by employees performing the type of work involved.

9.3(b) If based on a variety of factors (including but not limited to the nature of the assignment, the status of the program, the overall need for the skills at issue, and the purpose of using Contract personnel described above) the Company needs the skills supplied by Contract personnel on a long-term basis, the position shall be made available in accordance with the Boeing job posting process.

9.3(c) The Company and the Union agree that it is normally inappropriate to hire Contract personnel as direct hires in periods of surplus activity within a Job Classification or Skills Management Codes. Deviations will be subject to approval by the appropriate senior-level executive for the Major Organization. The Company will notify the Union prior to granting any deviation. The granting of a deviation to allow such hiring shall not be subject to the grievance and arbitration procedure of Article 3.

9.3(d) Contract personnel shall not be authorized to make decisions normally associated with management responsibility including salary determination, retention and discipline.

9.3(e) No employee from a surplussing Major Organization shall be laid off while Contract personnel are still employed in that Skills Management Code within that Major Organization, except those employees as to whom there is supporting documentation of performance deficiencies. No employee with an assigned retention rating of R1 or R2 shall be laid off from a surplussing Major Organization while Contract personnel are still employed in that skills management code within that, or any other, Major Organization.

9.3(f) Exceptions to this Article to avoid significant disruption or impact on committed packages of work will require the approval of the affected Major Organization Senior Human Resources person within the Major Organization and the concurrence of the Functional Director, who reports to the General Manager. Notification will be provided to the Union as soon as practicable.

Section 9.4 Data. Upon request, the Company shall supply the Union with data that displays the number of contract personnel utilized by Skills Management Code by Major Organization, so that compliance with all limitations identified in 9.3 can be monitored. The data shall include names, Skills Management Codes as applicable, organizations, and start dates.

ARTICLE 10
JOINT MEETINGS

Section 10.1 Joint Meetings.

10.1(a) Should either party desire to discuss with the other any matter affecting generally the relationship of the parties, a meeting of Union and management representatives shall be arranged upon request of either party. Such meeting shall take place at a time mutually convenient to both parties. Any use of Company time for attendance at such meetings shall be arranged in advance by mutual agreement.

10.1(b) This Article is intended to provide an open avenue of communication between the Union and the Company, and suggestions, complaints, or other matters may be presented by either party, provided that neither party shall be required to discuss any item brought up by the other party nor be bound to act upon any item presented. However, both parties agree to discuss informal grievances and complaints.

ARTICLE 11
WORK SCHEDULES – PAY RATES – OVERTIME – TEMPORARY MILITARY LEAVE – JURY DUTY AND WITNESS SERVICE

Section 11.1 Full Time Work Schedules.

11.1(a) Each employee working full time shall be assigned one of the following work schedules:

(1) Category 1 Weekday Schedule: 40 hours in a work week or 80 hours in a pay period, with regular workdays during the Monday through Friday period.

(2) Category 1 Weekend Schedule: 40 hours in a work week or 80 hours in a pay period, with Saturday and/or Sunday as a regular workday.

(3) Category 2 Weekday Schedule: Less than 40 hours in a work week or less than 80 hours in a pay period, with regular workdays during the Monday through Friday period.

(4) Category 2 Weekend Schedule: Less than 40 hours in a work week or less than 80 hours in a pay period, with Saturday and/or Sunday as a regular workday.

WORK SCHEDULES

Schedule Hours	Category One Schedules of *40 hours in a work week or* 80 hours in a pay period		Category Two Schedule with fewer than *40 hours in a work week or* 80 hours in a pay period	
Schedule Type	**Weekday**	**Weekend**	**Weekday**	**Weekend**
Shift	**Incentives**			
First	None	Weekend Rate	Schedule Factor	Weekend Rate Schedule Factor
Second	Shift Rate	Shift Rate Weekend Rate	Shift Rate Schedule Factor	Shift Rate Weekend Rate Schedule Factor
Third	Shift Rate Shift Percentage	Shift Percentage Shift Rate Weekend Rate	Shift Rate Schedule Factor	Shift Rate Weekend Rate Schedule Factor

INCENTIVES DEFINITIONS

Shift Percentage Maintains "equity" with 3rd shift 6.5 hour schedule	**Shift Rate** Working other than 1st shift	**Weekend Rate** Working on a Saturday/Sunday as a regular day	**Schedule Factor** Works less than 40/80 hours, paid for 40/80
23%	$.75 per hour	Sat. or Sun. $1.50 Sat. & Sun. $2.00	Pay period hours/ Scheduled hours

Employees may, at their request and with management's approval, work any of the above schedules. Employees working schedules at their request for personal reasons, and in the absence of a company requirement for such a schedule, will not be eligible for Work Schedule Incentives. Management will staff work schedules with volunteers; in the absence of a sufficient number of volunteers, the Company may assign individuals to work required schedules. Whenever possible, employees will be consulted to develop workable schedules.

11.1(b) Non-exempt employees may, at their request and with management's approval, make a temporary modification of their work schedule through movement of hours from one day to another within a forty (40)-hour work week. Exempt employees may, at their request and with management's approval make a temporary modification of their work schedule through movement of hours from one day to another within an 80-hour pay period.

11.1(c) The Company will attempt to establish work schedules with at least two (2) days designated as days of rest.

Section 11.2 Incentives.

11.2(a) An employee assigned to the second or third shift shall receive a shift rate incentive of seventy-five cents ($0.75) per hour, which shall be added to his or her base salary and made a part thereof.

11.2(b) An employee assigned to either Saturday or Sunday as a regular day of work shall receive $1.50 per hour added to his or her base salary and made a part thereof while so assigned. An employee assigned to both Saturday and Sunday as regular days of work shall receive $2.00 per hour added to his or her base salary and made a part thereof.

11.2(c) Employees assigned to a Category 2 schedule shall receive a schedule factor incentive equivalent to the difference between the hours scheduled and forty (40) hours in a workweek.

11.2(d) Employees assigned to a Category 1 schedule and identified to receive the 'shift percentage' shall receive twenty-three percent (23%) of their base rate, which shall be added to their base salary and made a part thereof.

Section 11.3 Shifts and Lunch Periods.

11.3(a) Each employee shall be assigned to a definite shift with designated beginning and ending times.

11.3(b) Non-exempt employees will work schedules which provide a fixed unpaid meal period to start not more than five (5) hours after start time, consisting of a forty (40)-minute lunch period, ten (10) minutes of which shall be paid time and thirty (30) minutes of which shall be unpaid. Non-exempt employees working in excess of an eleven (11)-hour shift are entitled to a second unpaid meal period, to start not more than eight (8) hours after start time, consisting of a minimum of thirty (30) minutes. Meal periods will be paid if the employee is not fully relieved of his or her duties.

11.3(c) The Company may assign an individual employee or groups of employees to any shift to meet operational requirements. The following shift identification will apply:

(1) A shift which begins at any time between 4:00 a.m. and 11:59 a.m. (both times inclusive) will be designated as first shift.

(2) A shift which begins at any time between 12:00 noon and 7:59 p.m. (both times inclusive) will be designated as second shift.

(3) A shift which begins at any time between 8:00 p.m. and 3:59 a.m. (both times inclusive) will be designated as third shift.

11.3(d) Report Time For Non-exempt Employees.

11.3(d)(1) A non-exempt full-time employee who, in accordance with instructions, reports for work on his or her assigned shift will be paid at base salary and any applicable shift bonus for no less than the scheduled hours for that shift.

11.3(d)(2) If a non-exempt employee works his or her assigned shift or portion thereof and also reports, in accordance with instructions, for one (1) or more additional separate work periods on the same day, he or she will receive a minimum of four (4) hours pay at base salary for each such work period.

11.3(d)(3) If a non-exempt full-time employee, in accordance with instructions, reports for one (1) work period on a scheduled day of rest or on a holiday, he or she will receive a minimum of eight (8) hours pay at base salary for that work period.

11.3(d)(4) If a non-exempt employee, in accordance with instructions, reports for one (1) or more additional separate work periods on the day of rest or holiday, he or she will receive a minimum of four (4) hours pay at base salary for each such work period. These minimum report time requirements will not apply in case of emergency shutdown arising out of any condition beyond the Company's control.

11.3(d)(5) Non-exempt employees who leave work of their own volition or because of incapacity (other than industrial injury or illness), or are discharged or suspended after beginning work, will be *paid only for the number of hours actually worked during that day.*

Section 11.4 Part-Time Employees. Any employee whose work schedule consists of a seven (7)-day cycle with fixed days and hours of work that are less than forty (40) hours over a regular work week, or a fourteen (14)-day cycle with fixed days and hours of work that are less than eighty (80) hours over two regular work weeks, and is not on a Category 2 Schedule, shall be considered as a part-time employee and shall be subject to all provisions of this Agreement except as otherwise provided in 11.4(a) through 11.4(f).

11.4(a) ***Shifts and lunch periods*** *for part-time employees will be assigned in accordance with* Company procedures and will not be subject to 11.3. Meal periods will be paid if the employee is not fully relieved of his or her duties. .

11.4(b) Work Schedule Incentives. Employees assigned to second or third shift may receive a shift rate and a schedule factor incentive. Employees are not eligible to receive the weekend rate incentive.

11.4(c) Holidays. Employees are eligible for holiday pay if they are scheduled to work twenty (20) *or more hours in a seven (7)-day cycle or forty (40) or more hours in a fourteen (14)-day cycle.* Payment will be four (4) hours of holiday pay for each Company holiday, regardless of the calendar day or hours scheduled on the respective holiday.

11.4(d) Overtime. The provisions of 11.8 do not apply to part-time employees. Employees will be paid overtime for hours in excess of forty (40) compensated hours in a work week. *All* overtime, except on holidays, will be paid at time and one-half. Hours worked on a holiday will be paid per the provisions of Article 7.

11.4(e) Jury Duty and Witness Service. Employees are eligible for jury duty and witness service pay if they are scheduled to work twenty (20) or more hours in a seven (7)-day cycle or forty (40) or more hours in a fourteen (14)-day cycle. Payment will be four (4) hours for each day served, regardless of calendar day or hours scheduled.

11.4(f) Other Pay Practices. Exempt employees on part-time schedules will continue to be identified as Paycode 6 but will be treated as non-exempt for all pay practices. Employees on part-time *work schedules shall not be eligible for leave with pay and may not charge time to personal business.*

Section 11.5 Pay Rates and Selective Salary Adjustments.

11.5(a) The Company will establish and distribute, in a manner consistent with Company guidelines, three selective salary adjustment funds in accordance with the dates set forth in Table I:

TABLE I

SELECTIVE SALARY ADJUSTMENT FUND COMPUTATION DATES, EFFECTIVE DATES, AND INCREASE PERCENTAGES

Review Period	Beginning Date	Fund Computation Date	Increase Effective Date	Ending Date	Increase Percentage	Minimum Increase
1	3/6/03	3/5/04	3/5/04	3/5/04	3.5%	$750
2	3/6/04	1/21/05	3/4/05	3/4/05	3.0%	$500
3	3/5/05	1/20/06	3/3/06	3/3/06	3.0%	$0
4	3/4/06	1/19/07	3/2/07	3/2/07	Market*	$750

**Market is defined in section 11.5(c) below.*

11.5(b) Base salaries of eligible employees will be increased from a fund computed by multiplying the Increase Percentage by total salaries of eligible employees and subtracting from the product any increases accomplished without change of level during the review period. All increases will be effective on the Increase Effective Date of the review period and will be rounded to the nearest $50. Eligible employees are those classified in the bargaining unit and on the active payroll on both the Fund Computation Date and the Increase Effective Date. Occasionally employees will receive lump sums in lieu of or in addition to base salary increases. Said lump sum payments will count toward the expenditure of the funds.

11.5(c) The "Market" rate for the 2007 salary increase is to be determined by reviewing a number of factors which include:

- The relative position of salaries to the market which is called the *comparatio.*
- The estimated market salary escalation as determined by the SIRS poll or other like salary survey.
- Consideration of mitigating factors which would include local market differentiation and the relative leveling of positions.
- Any other relevant factors which the parties may agree upon.

The Company will look at these factors, consult with the union and determine the increase percentage. The final determination shall be made by the Company. The Company's determination of the increase percentage shall not be subject to the grievance and arbitration procedure detailed in Article 3.

11.5(d) The Company in its sole discretion may selectively increase base salary rates of individual employees on effective dates other than the Increase Effective Dates in Table I (out-of-sequence increases).

11.5(e) Cost of Living Adjustments.

11.5(e)(1) Employees eligible to participate in the selective adjustment funds under 11.5(a) may also receive Cost of Living Adjustments to the extent such adjustments become effective under and in accordance with all of the terms, conditions and limitations stated in the Section 11.5(e). The terms, definitions, and limitations stated in 11.5(a) and 11.5(b) also apply to such adjustments. Cost of Living Adjustments would be delivered to each eligible employee separately from those selective adjustment funds derived in 11.5(a). Cost of Living Adjustments would be effective on the dates specified in Table I.

11.5(e)(2) Determination of Cost of Living Adjustments shall be made in reference to the series U.S. city average "Consumer Price Index Urban Wage Earners and Clerical Workers" published by the Bureau of Labor Statistics, U.S. Department of Labor, with the following base period: 1982-1984 = 100, such Index being referred to herein as the BLS Index.

11.5(e)(3) Computations will be made using the three (3)-month average of the BLS Index for July, August and September 2000 as the base period.

11.5(e)(4) During the life of this Agreement, Cost of Living Adjustments shall be computed using the three-month average of the BLS Index for the periods specified in Table II and the corresponding BLS Index threshold values expressed as percentage increases over the 2000 base period. The formula will be: percentage of Cost of Living Adjustment equals fifty percent (50%) of the percentage increase in the BLS Index, from the 2000 base period to the BLS Index Comparison Quarter, that exceeds the BLS Index Threshold Percentage shown in Table II. In order to preclude recognition, on more than one effective date, of the same percentage increase in the BLS Index, any recognition on one effective date of a percentage increase over the applicable BLS Index Threshold Percentage will cause that percentage to be set aside and

disregarded in ensuing computations. [E.g., if the BLS Index for October, November, and December 2003 represented a 12.0 percent increase over the base period (yielding a 2.5 percent Cost of Living Adjustment effective March 5, 2004), no Cost of Living Adjustment would result for the March 4, 2005, effective date unless, and to the extent, the BLS Index for October, November, and December 2004 represented an increase in excess of 18.2 percent (18.2%) over the base period.] BLS Index three (3)-month averages, BLS Index increase percentages, and salary increase percentages will be rounded to the nearest tenth, with five hundredths rounded upward to the nearest tenth.

TABLE II

Effective Date of Adjustment	BLS Index Comparison Quarter	BLS Index Threshold Percentage
3/5/2004	Oct, Nov, Dec 2003	7.0%
3/4/2005	Oct, Nov, Dec 2004	13.2%
3/3/2006	Oct, Nov, Dec 2005	19.6%
3/2/2007	Oct, Nov, Dec 2006	26.2%

11.5(e)(5) In connection with each of the effective dates in Table II, the computations set forth in 11.5(e)(4) will be made.

Section 11.6 Temporary Military Leave. An employee who is a member of a reserve component of the Armed Forces, who is absent due to required active annual training duty or temporary special services duty, shall be paid his or her normal straight time earnings, including shift differential where applicable, up to a maximum of 80 hours each military service fiscal year. The amount due the employee under this 11.6 shall be reduced by the amount received from the government body identified with such active or temporary special duty, for the period of such duty (up to the maximum period mentioned above). Such items as subsistence, uniform and travel allowance shall not be included in determining pay received from the state or federal government. An employee who elects to work or use available vacation credits while on temporary active duty shall not be eligible for military pay differential for that period.

Members of a reserve component of a uniformed service ordered to annual active duty are eligible for military differential pay up to a maximum of eighty (80) hours each military fiscal year (October 1 - September 30).

Members of a reserve component of a uniformed service ordered to temporary special duty under Military U.S. Code Title 10 or mobilized by the applicable state agency are eligible for military differential pay up to a maximum of ninety (90) calendar days for each occurrence.

Employees will retain all compensation received from the uniformed services. If this compensation is less than their regular Company pay (base rate plus applicable additives), the Company will provide pay equal to the difference between the employee's base rate (plus applicable additives) and the compensation received from the uniformed services. This pay will be provided upon receipt of the employee's leave and earnings statement. Subsistence (does not include quarters), uniform, and travel allowances will not be included in determining military pay.

Section 11.7 Jury Duty and Witness Service. Time off with pay, up to thirty (30) days each calendar year, will be granted for absence necessary for an employee to perform jury duty or witness service. The employee will retain all fees received. Time off with pay will not be granted if the employee:

(1) Is subpoenaed as a witness against the Company or its interests.

(2) Is subpoenaed as a witness as a direct party in the action.

(3) Voluntarily seeks to testify as a witness.

(4) Is subpoenaed as a witness in a case arising from or related to the employee's outside employment or outside business activities.

Deviations to this procedure must be approved by Company Offices Compensation and Benefits.

Section 11.8 Overtime.

11.8(a) The Company will attempt to meet its overtime requirements on a voluntary basis among the employees. In the event there are insufficient volunteers to meet requirements, management may designate and require the necessary number of employees to work the overtime.

11.8(b) Category 1 Schedules Non-exempt Employees. For time worked in excess of forty (40) compensated hours in a work week, other than the 2nd day of rest, an employee shall be paid one and one-half times his or her base rate. All time worked on the second day of rest will be paid at double his or her base rate after forty (40) compensated hours in that work week. All overtime worked in excess of twelve (12) hours in a work week will be paid at double his or her base rate.

11.8(c) Category 2 Schedules Non-exempt Employees. For time worked in excess of scheduled and compensated hours in a work week, other than the 2nd day of rest, an employee shall be paid at one and one-half times his or her base rate. All hours worked on the second day of rest will be paid at double his or her base rate after scheduled and compensated hours in a work week. All overtime worked in excess of twelve (12) hours in a work week will be paid at double his or her base rate.

11.8(d) Category 1 and 2 Schedules Exempt Employees. The hourly rate to be paid for scheduled overtime worked by employees will be straight time plus $6.50 per hour.

11.8(d)(1) The term 'scheduled overtime' as used in this paragraph will refer to a program of work in excess of eighty (80) compensated hours in a two-week pay period authorized as scheduled overtime by the Company to meet increased workload.

11.8(d)(2) The provisions of 11.8(d) will not be applicable to the following:

11.8(d)(2)(i) Employees on part-time work schedules.

11.8(d)(2)(ii) Time enroute on travel assignments at the request of the Company.

11.8(d)(2)(iii) All hours worked in excess of the scheduled hours which are not requested by the Company.

Section 11.9 Labor Charging. Except as expressly provided in this Agreement, the Company shall have the right to require employees to record time worked (however categorized) and to administer the overtime and all other aspects of its labor charging system in the manner the Company may determine from time to time.

ARTICLE 12
UNION OFFICIALS

Section 12.1 Accredited Representatives.

12.1(a) The Union shall inform the Company in writing of the names and positions of its officials and, currently, any changes thereto. Only persons so designated to the Company will be accredited as representatives of the Union. Accreditation shall be effective on the third day following the Company's receipt of the notification.

12.1(b) Solicitation of Union membership, collection or checking of dues, or reading of Union newsletters or publications will not be permitted during working time. Distribution of Union

newsletters or publications will not be made during working time or in work areas. The Company agrees not to discriminate in any way against any employee for legitimate Union activity, but such activity shall not be carried on during working time except as specifically provided for in this Agreement.

12.1(c) Each employee, before leaving his or her assigned work on Union business, shall have authorization therefore from the Union and shall notify his or her supervisor prior to taking such leave. The Union shall provide to the designated Company Representative oral confirmation of such authorization at least one (1) day prior to such leave and written confirmation immediately thereafter. Such un-worked time, limited to regular working hours, shall be charged to a special charge account number and the Union agrees to reimburse the Company at the employee's regular hourly rate for all such time so spent.

12.1(d) Grievance and Contract Administration.

12.1(d)(1) The Union shall investigate and adjust grievances and perform contract administration, in the work area, exclusively through Executive Board members and Council Representatives, who shall be employees, and Union Staff Representatives.

12.1(d)(2) Each Executive Board Member and Council Representative shall notify and obtain permission from his or her supervisor before leaving the work assignment for the purpose of investigating complaints or claims of grievance on the part of employees in his or her work area. Such permission shall be granted except where the supervisor considers such absence would seriously interfere with the performance of the group of which the representative is a part. Time spent on such approved investigations and discussions shall be considered work time provided such activity does not extend beyond the time that the supervisor considers reasonable under the circumstances. Any Executive Board Member and Council Representative in the conduct of his or her investigation, and before contacting an employee, shall obtain permission of the supervisor of such employee and advise the supervisor of the nature of the complaint or grievance and the estimated time required for the discussion. Such permission shall be granted except where the visit would seriously interfere with the work of the group. Except as provided in 12.1(e) and 10.1(a), all time lost from work due to such Union business shall be handled in accordance with 12.1(c).

12.1(d)(3) Access by Union Staff Representatives shall be governed by 12.2 below.

12.1(e) Leave of absence of at least thirty (30) days without pay shall be granted for the following reasons:

12.1(e)(1) Full-time employment by the Union or its national organization.

12.1(e)(2) Union business authorized by the Executive Board and approved in writing by the designated Company Representative, which approval shall not be withheld absent legitimate business circumstances.

The Company will reinstate employees on such leaves at not less than his or her former grade level and salary plus any general salary increases that occurred during the period of the leave of absence.

12.1(f) The Company and the Union recognize that each individual within the bargaining unit has a full-time work assignment for the Company and, if Union business impairs performance of such work assignment, the Company and Union agree to make arrangements to prevent such impairment in the future.

12.1(g) Executive Board and Council.

12.1(g)(1) The Union may designate one (1) Council Representative for each 200 employees, or major fraction thereof, in each Major Organization in the bargaining unit. In unique

circumstances where maintaining such a ratio creates a hardship to the Union, the Company will give due consideration to a written request from the Union for a waiver of the ratio requirement.

12.1(g)(2) The parties will review bi-annually, prior to Council elections, the number of Council Representatives allowed under 12.1(g)(1). The number agreed upon as contractually allowable during these reviews may not be reduced prior to the next such review except by mutual agreement of the parties. Any increases to the number of Representatives must be in accordance with 12.1(g)(1) and is also subject to mutual agreement of the parties.

12.1(g)(3) No more than seven (7) Executive Board members shall at any time be accepted by the Company as accredited representatives of the Union.

12.1(g)(4) In the absence of a Council Representative for any reason, the Union may designate a temporary substitute.

12.1(h) Protection of Union Officials.

12.1(h)(1) Executive Board members and Council Representatives shall not be laid off during their respective terms of office except as described herein.

12.1(h)(1)a Executive Board members and Council Representatives will be given a retention rating while serving during their term of office that will be adjusted to indicate that the employee has the highest retention rating in the applicable skill or job activity code. So rated, the Representatives will be subject to all terms and conditions of Article 8 of the parties' Agreements. Once the Representatives are no longer in office, the retention rating will be re-adjusted to the otherwise applicable rating.

12.1(h)(1)b If Council Representatives are relocated, due to transfer or otherwise, out of the district in which they were elected, the Representatives will continue to be protected from layoff for the balance of their term of office so long as they remain recognized members of the Council. Each designated Council position can be filled by only one (1) member.

12.1(h)(1)c Layoff protection does not apply to Executive Board Members and Council Representatives who, at the time of election or appointment, have received an active advance notice of potential layoff, unless the Board Member or Representative is running for reelection to a consecutive term of office.

12.1(h)(1)d Nothing herein precludes an Executive Board Member or Council Representative from requesting a voluntary or accelerated layoff.

12.1(h)(2) In the event management deems it necessary to involuntarily transfer or loan a Council Representative, and other employees then represented by the Council Representative would remain in the same skill code, when practicable the Company will inform the Union of the proposed transfer or loan thirty (30) days prior to its effective date and will discuss with the Union the feasibility of transferring or loaning another employee.

Section 12.2 Union Staff Representatives' Access to Plants. Union Staff Representatives not employed by the Company will be permitted access during working hours to areas in the Company's facilities where employees in the bargaining units defined in Article 1 are assigned, to the extent government and customer regulations permit. Unless mutually agreed in advance, such access shall be only for the purpose of investigating complaints or claims of grievance on the part of employees or the Union and shall be subject to the following:

12.2(a) The Company shall be required to admit only those Staff Representatives who have been agreed to in writing or as may be agreed to by the Company throughout the remainder of the

Agreement. Except for visits to the Corporate Union Relations Offices, Staff Representatives shall notify the designated Human Resources organization of their contemplated visits.

12.2(b) Staff Representatives who are entitled to admittance to the Company's facilities shall sign in where required through the Company designated organization at the plant or facility they desire to enter. Upon being admitted, they shall proceed to the organization they wish to visit, contact the supervisor then present, inform him or her of the purpose of their visit and obtain his or her permission prior to contacting any employee in such organization. Such permission will be granted except where there is a substantial reason for delaying the contact due to safety conditions or the fact that a critical operation is in process. Upon leaving the plant or facility, they shall sign out where required and return any temporary identification badges that were issued for the purpose of the specific visit.

12.2(c) The Company shall supply identification badges so that each Union Staff Representative can have access during working hours to the areas in which Bargaining Unit employees are assigned. Staff Representatives may retain their badges affording such access during the period they are assigned such duties by the Union, subject to 12.2(a), 12.2(b), and 12.2(d) of this Agreement.

12.2(d) Staff Representatives who fail to comply with provisions of 12.2 shall forfeit their admittance rights.

ARTICLE 13
DEDUCTION OF UNION DUES

Section 13.1 Deduction of Union Dues. The Company agrees to make monthly payroll deductions for the Union's dues upon receipt by the office designated by the Company of a voluntary written assignment covering such deductions on a form mutually agreed to by the Union and the Company. Such assignment is to remain in effect until cancelled by the bargaining unit employee so signing on a Company form or in any other written manner acceptable to the Company. This notification of cancellation must be mailed or delivered separately to the Company and the Union (SPEEA-Wichita, 973 South Glendale, Wichita, KS 67218). The cancellation shall become effective no later than the month following the month in which the notification is received.

The Company will carry over dues authorizations of employees among and between the bargaining units represented by the Union; i.e., where a valid authorization card is on file with the Company for an employee within a bargaining unit and the employee thereafter is transferred directly to one of the other Union bargaining units and the employee has not in the meantime cancelled the authorization.

Section 13.2 Union Dues Tables. In the event the Union desires to change the present method of computing the amount of dues to be deducted, the Union will obtain written Company approval of the proposed method prior to the change becoming effective through payroll deduction.

Section 13.3 Indemnification and Waiver of Claims. The Union expressly agrees to indemnify the Company against any and all employee and governmental claims, demands, suits or other forms of liability that arise out of or by reason of action taken or not taken by the Company for the purposes of complying with this agreement to deduct Union dues.

Both the Company and the Union will utilize due diligence in administering and reviewing, respectively, the dues deduction system. In the event the Union discovers administrative errors in Company administration of the system, the Union will give the Company prompt and timely notice of same, whereupon the Company will endeavor to make reasonable administrative corrections consistent with applicable state and federal law. Respecting Company administration of the system, the Union expressly waives as against the Company any and all claims, demands, suits or other forms of liability that may arise out of or by reason of good faith action taken or not taken by the Company for purposes of complying with this Article.

Section 13.4 Offsets. The Union agrees that, subject to ongoing Union approval, the Company can offset amounts the Union owes the Company for time charged by employees to Union charge numbers for Union business as detailed in Section 12.1(c) from the monthly dues payments collected by the Company for the Union. The Company will provide a monthly accounting to the Union of all offsets. The parties will agree on guidelines for making such deductions prior to implementing this Section.

ARTICLE 14
STRIKES AND LOCKOUTS

Section 14.1 Strikes and Lockouts.

14.1(a) The Union agrees that during the term of this Agreement and regardless of whether an unfair labor practice is alleged, (a) there shall be no strike (whether it be an economic strike, sympathy strike, or otherwise) slow down, walk out, boycott, picketing, or any other interference with the Company's operations by bargaining unit members, including any refusal to cross any other labor organization's or other party's picket line and (b) the Union shall not directly or indirectly authorize, encourage, ratify, assist in, condone or approve any refusal on the part of employees to proceed to the location of normal work assignment. Nothing in 14.1 shall require employees to work in an unsafe environment. Any employee who violates this Article may be subject to disciplinary action.

14.1(b) The Union will make every effort to stop and discourage any action prohibited by 14.1 if it should occur and will keep the Company advised of its actions.

14.1(c) The Company agrees that there shall be no form of lockout during the term of this Agreement.

14.1(d) Any claim by either the Company or the Union that this Article has been violated shall not be subject to the grievance and arbitration provisions of this Agreement, and either party shall have the right to submit such claims to the courts.

ARTICLE 15
VOLUNTARY INVESTMENT PLAN

Section 15.1 Continuation of Plan. Subject to the continuing approval of the Commissioner of Internal Revenue and of other cognizant governmental authorities, as more particularly hereinafter specified, and to the provisions of 15.4, a Voluntary Investment Plan (hereinafter called the Plan) in the form as now in effect as to the employees within the unit to which this Agreement relates shall continue to be effective while this Agreement is in effect as to such employees in accordance with and subject to the terms, conditions and limitations of the Plan.

Section 15.2 Approval of Plan. Approval of the Plan by the Commissioner of Internal Revenue as referred to in 15.1 means a continuing approval sufficient to establish that the Plan and related trust or trusts are at all times qualified and exempt from income tax under Section 401(a), Section 401(k) and other applicable provisions of the Internal Revenue Code of 1986, and that contributions made by the Company under the Plan are deductible for income tax purposes in accordance with law. The cognizant governmental authorities referred to in 15.1 include, without limitation, the Department of Labor and the Securities and Exchange Commission, and their approval means their confirmation with respect to any matter within their regulatory authority that the Plan does not conflict with applicable law.

Section 15.3 Continuation beyond Agreement. The Company shall not be precluded from continuing the Plan in effect as to employees within the units to which this Agreement relates after expiration or termination of this Agreement, subject to the terms, conditions, and limitations of the Plan.

Section 15.4 Changes to the Current Plan. Subject to action by the Company's Board of Directors (or its delegate) and to the approvals specified in 15.2, all provisions of the current Plan applicable to

employees covered by this Agreement are to remain unchanged including the Company's match of seventy-five percent (75%) of the first eight percent (8%) of base pay contributed by a plan Member. The following changes are effective October 1, 2004.

1. Employees enrolled in the Plan may contribute between one percent (1%) and twenty percent (20%) of their qualifying compensation in one percent (1%) increments on a pre-tax and/or after tax basis.

2. The Boeing Stock fund portion of the VIP will be designated as an Employee Stock Ownership Plan. Employees who have all or a portion of their VIP account invested in the Boeing Stock Fund will be able to choose a one hundred percent (100%) cash payment of dividends. Alternatively, employees may continue automatic reinvestment of those dividends.

Section 15.5 Required Plan Amendments. The Company reserves the right to amend the Plan to satisfy all requirements of Section 401(a), Section 401(k) or any other applicable provision of the Internal Revenue Code of 1986. Additionally, when the Company identifies administrative services that in its estimation reflect industry best practices, the Employee Benefit Plans Committee has discretion to adopt these changes to the Savings Plan. The Company will notify the Union in advance of implementation of any changes adopted by the Employee Benefit Plans Committee.

Section 15.6 Participant Elective Contributions Not Applicable for Other Purposes. It is acknowledged that the election of a Member to convert a portion of his or her base pay under the terms of the Plan will be effective for purposes of this Plan and will reduce the Member's compensation insofar as certain payroll taxes may be applicable. However, for all other employment-related purposes, including all of the Member's rights and privileges under this labor agreement, his or her base pay or compensation will be considered as though no election had been made.

ARTICLE 16
GROUP BENEFITS

Section 16.1 Type of Group Benefits Package for Employees on the Active Payroll. The Company will continue until September 30, 2004, the existing health care, disability and life package. Effective October 1, 2004, the Company will provide the life benefits, accidental death and dismemberment benefits, medical benefits and dental benefits for eligible employees and medical benefits and dental benefits for covered dependents of eligible employees as summarized in the document entitled Attachment A, as the Group Benefits Package. Additionally, the Company will provide access to the optional Voluntary Personal Accident Plan and Long-Term Disability Plan as offered to other SPEEA-represented employees in Wichita and the Supplemental Life and Short-Term Disability Plan currently provided to employees within this unit. Employees will be required to pay for these benefits. Effective January 1, 2005, employees may also contribute, on a pre-tax basis up to a maximum of $3,000, to a Health Care Reimbursement Account Plan for qualifying expenses.

Section 16.2 Cost of the Group Benefits Package for Employees on the Active Payroll.

16.2(a) Life and Accidental Death and Dismemberment Benefits. The Company will pay the full cost of the Life and Accidental Death and Dismemberment Plans for eligible employees.

16.2(b) Medical Benefits.

16.2(b)(1) The current contributions for the Traditional Medical Plan will continue through September 30, 2004.

16.2(b)(2) Effective October 1, 2004, in regions where employees may choose between the Traditional Medical Plan and a coordinated care plan, the Company will pay the full cost of the lowest-cost plan in the applicable region for eligible employees and dependents. Employees

and dependents that elect coverage under a higher cost plan will contribute on a pre-tax basis twelve percent (12%) of the cost of the plan the employee chooses.

16.2(b)(3) Effective July 1, 2005, in regions where employees may choose between the Traditional Medical Plan and a coordinated care plan, the Company will pay the full cost of the lowest-cost plan in the applicable region for eligible employees and dependents. Employees and dependents that elect coverage under a higher cost plan will contribute on a pre-tax basis 18 percent (18%) of the cost of the plan the employee chooses. The monthly contribution will not exceed $89 for an employee only, $178 for either an employee and spouse or an employee and child(ren) and $267 for an employee and family in years 2004, 2005 and 2006.

16.2(b)(4) For employees who live in areas where coordinated-care plans are not available, the Company will pay the full cost of the Traditional Medical Plan.

16.2(b)(5) The employee is required to contribute an additional $100 each month for medical coverage under the Group Benefits Package to enroll a spouse if the spouse is eligible for medical coverage under another employer-sponsored plan and waives such coverage. This $100 contribution will not be required for a spouse who waived coverage under another employer-sponsored plan prior to eligibility for medical coverage under the Group Benefits Package, provided the spouse enrolls at the other plan's next enrollment period or, if earlier, at an enrollment date allowed by the other plan.

16.2(c) Dental Benefits. The Company will pay the full cost of the Preferred Dental Plan, Scheduled Dental Plan or the Prepaid Provider Dental Plan.

16.2(d) Part-time Employees. Employees on part-time work schedules will be offered a benefits package in accordance with standard Boeing policy, PRO-522.

Section 16.3 Type of Retiree Medical Plan. The Company will continue until December 31, 2001, the existing retiree medical plan that is currently offered for employees hired prior to January 1, 1999. Thereafter, the Company will provide for the duration of this Agreement the medical benefits for eligible retired employees hired prior to January 1, 1999, and for covered dependents of eligible retired employees as summarized in the document entitled Attachment B, effective January 1, 2002, or on such later date when specifically stated therein and subject to all of the terms and conditions contained in or referred to in such Attachment B.

Section 16.4 Cost of the Retiree Medical Plan. The Company will share the cost of medical coverage for current and future eligible retired employees as follows:

16.4(a) Effective October 1, 2004, Company and retired employee contributions will be as follows:

For any coordinated care/health maintenance organization plan coverage, retired employees will contribute $10 for a retired employee only, $20 for a retired employee and spouse, $20 for a retired employee and child(ren), or $30 for a retired employee and family. For Traditional Medical Plan coverage, retired employees will contribute $20 for a retired employee only, $40 for a retired employee and spouse, $40 for a retired employee and child(ren), or $60 for a retired employee and family. The Company will pay the cost of each plan in excess of the amount contributed by retired employees. Any Company contribution will be made only for an eligible retired employee who meets the eligibility requirements of the Retiree Medical Plan and authorizes deduction of the balance of plan rates, if any, from his or her retirement check or agrees to make timely self-payments for such coverage. Such employer contribution will continue for an eligible retired employee or eligible spouse, except as described in 16.4(c), until such eligible person attains 65 years of age or is earlier eligible for Medicare, and for a dependent child, until such child is no longer an eligible dependent or earlier qualifies for Medicare, or until such eligible person fails to make timely self-payment of a required contribution.

16.4(b) For employees who were hired on or after January 1, 1993, and before January 1, 1999, the Company contributions are limited to three and one-third percent (3-1/3%) of the cost of the coordinated care/health maintenance organization plan or Traditional Medical Plan the retired employee chooses per year of service for the duration of the Agreement. Retired employees pay the difference (the cost of the plan minus the Company contributions). However, all covered retired employees must make contributions not less than specified in 16.4(a).

16.4(c) The retired employee is required to contribute $100 each month to enroll a dependent spouse in the Retiree Medical Plan if the spouse is eligible for coverage under another employer-sponsored plan as an active employee and waives such coverage. This $100 contribution will not be required for a spouse who waived coverage under another employer-sponsored plan prior to eligibility for medical coverage under the Group Benefits Package, provided the spouse enrolls at the other plan's next enrollment period or, if earlier, at an enrollment date allowed by the other plan or for a spouse who is employed part-time.

Section 16.5 Details and Method of Coverage. The benefits summarized in the Group Benefits Package and the Retiree Medical Plan shall be procured by the Company under contracts and/or administrative agreements with insurance companies, health care contractors or administrative agents which will be in the form customarily written by such carriers and administrative agents, and the Group Benefits Package and Retiree Medical Plan shall be subject to the terms and conditions of such contracts and/or administrative agreements, consistent with the summary in the Group Benefits Package or Retiree Medical Plan.

Such contracts and/or administrative agreements will require the administrative agents to develop various programs and procedures designed to contain costs based on those portions of the Group Benefits Package and the Retiree Medical Plan that contain the requirement that charges are covered only on the basis of medical necessity. Such cost containment programs or procedures may be utilized to determine the medical necessity of the treatment itself, the appropriateness of the services provided, the place of treatment or the duration of treatment. The administrative agents and the Company will announce each such program or procedure before it is required or available to the affected employees or retirees. Any such cost containment program or procedure will not operate to reduce or deny the benefit properly due under the Plans to any covered person or to shift the costs covered under the Plans to the covered person.

The failure of an insurance company, health care contractor or administrative agent to provide any of the benefits for which it has contracted shall result in no liability to the Company, nor shall such failure be considered a breach by the Company of the obligations that it has undertaken by this Agreement. However, in the event of any such failure, the Company shall immediately attempt to provide substitute coverage.

Section 16.6 Administration. The Group Benefits Package and the Retiree Medical Plan shall be administered by the insurance companies, health care contractors or administrative agents with whom the Company enters into contractual relationships for the purpose of providing and/or administering the coverage contemplated by the Group Benefits Package or the Retiree Medical Plan and no question of issue arising under the administration of such Group Benefits Package or the Retiree Medical Plan or the contracts and/or administrative agreements identified therewith shall be subject to the grievance and arbitration procedures of Article 3 of this Agreement.

Section 16.7 Copies of Policies to be furnished to Union. Copies of the policies, contracts, and administrative agreements executed pursuant to this Article 16 shall be furnished to the Union and the coverages and benefits indicated in the Group Benefits Package or the Retiree Medical Plan, the rights of eligible employees in respect of such coverages, and the settlement of all claims arising out of such coverages shall be in accordance with the provisions, terms and rules set forth in such contracts.

Section 16.8 Federal or State Packages. If during the term of this Agreement there is mandated by federal or state government a program that affords to employees and/or retirees covered by this Agreement

similar benefits (such as but not limited to medical benefits and dental benefits) to those that are afforded by this Agreement, benefits afforded by this Agreement will be replaced by such federal or state program. The Company will comply with the provisions for the furnishing of such program to the extent required by law. No question or issue regarding the level of benefits under the state or federal program will be subject to the grievance and arbitration procedures Article of this Agreement.

Section 16.9 Health Care Reimbursement Account Plan. The Health Care Reimbursement Account Plan will be effective January 1, 2005.

ARTICLE 17
RETIREMENT PLAN

Section 17.1 Continuation of Plan. Subject to the continuing approval of the Commissioner of Internal Revenue and of other cognizant governmental authorities, as more particularly hereinafter specified, and to the provisions of 17.5, a Retirement Plan (hereinafter called the "Plan" in the form now in effect as to the employees within the units to which this Agreement relates shall continue to be effective while this Agreement is in effect as to such employees in accordance with and subject to the terms, conditions, and limitations of the Plan.

Section 17.2 Approval of Plan. Approval of the Plan by the Commissioner of Internal Revenue as referred to in 17.1 means a continuing approval sufficient to establish that the Plan and related trust(s) are at all times qualified and exempt from income tax under Section 401(a) and other applicable provisions of the Internal Revenue Code of 1986, and that contributions made by the Company under the Plan are deductible for income tax purposes in accordance with law. The cognizant governmental authorities referred to in 17.1 include, without limitation, the Department of Labor, the Pension Benefit Guaranty Corporation and the Securities and Exchange Commission, and their approval means their confirmation with respect to any matter within their regulatory authority that the Plan does not conflict with applicable law.

Section 17.3 Continuation beyond Agreement. The Company shall not be precluded from continuing the Plan in effect as to employees within the units to which this Agreement relates after expiration or termination of this Agreement, subject to the terms, conditions, and limitations of the Plan.

Section 17.4 Grievances as to the Plan. Only questions concerning the amount of Credited Service under the Plan that an employee has accumulated by reason of employment after the effective date of the Plan shall be subject to the grievance and arbitration procedure of this Agreement.

Section 17.5 Changes to the Current Plan. Subject to action by the Company's Board of Directors (or its delegate) and to the approvals specified in 17.2, as well as any changes required by applicable law, all provisions of The Boeing Company Employee Retirement Plan are to remain unchanged with the exception of the following amendments:

17.5(a) Basic Benefit. The Basic benefit will be increased to $59 per month for all years of Credited Service for Employees on the active Payroll of the Company on or after October 1, 2004 (including those who retire from the employ of the Company on October 1, 2004).

17.5(b) Basic Benefit. The Basic benefit will be increased to $60 per month for all years of Credited Service for Employees on the active Payroll of the Company on or after January 1, 2005 (including those who retire from the employ of the Company on January 1, 2005).

Section 17.6 Administration of the Retirement Plan. The Company shall have the right to unilaterally make any changes in actuarial assumptions and funding methods, provided such changes are determined by the Plan's enrolled actuary to be reasonable in the aggregate. The Company shall be entitled to unilaterally adopt such amendments to the Plan as may be required in order to obtain any approval referred to in 17.1 and described in 17.2 of the Agreement.

ARTICLE 18
NON-DISCRIMINATION

Section 18.1 Non-Discrimination. All terms and conditions of employment included in this Agreement shall be administered and applied without regard to race, color, religion, national origin, status as a disabled or Viet Nam era veteran, age, sex, sexual preference, marital status, or the presence of a disability except in those instances where age, sex or the absence of a disability may constitute a bona fide *occupational qualification.*

Administration and application of the Agreement that is not in contravention of federal or state law shall not be considered discrimination under this Article. The parties recognize that the Company is required to comply with applicable federal and state disability discrimination laws, and agree that the Company may take actions necessary to stay in compliance. The Company agrees to notify the Union in advance in the event that compliance with such laws affects the employee rights set forth in this agreement.

Section 18.2 Non-Discrimination Grievances. Notwithstanding any other provision of Article 3, a grievance alleging a violation of this Article 18 shall be subject to the grievance and arbitration procedure of Article 3 only if it is filed on behalf of and pertains to a single employee. Class grievances under Article 18 shall *not be subject to the grievance and arbitration procedure under this Agreement.*

ARTICLE 19
SEVERABILITY

Section 19.1 Severability. Should any part hereof or any provision herein contained be rendered or *declared invalid by reason of any existing or subsequently enacted legislation or by any decree by a court* of competent jurisdiction, such invalidation of any such part or portion of this Agreement shall not invalidate the remaining portions hereof and they shall remain in full force and effect.

ARTICLE 20
This agreement has no Article 20.

ARTICLE 21
LAYOFF BENEFITS

Section 21.1 Establishment of Plan. The Company will establish a Layoff Benefit Plan to provide for lump sum or income continuation benefits as set forth in this Article. Such Plan will apply to employees who are laid off with an effective date on or after the effective date of this agreement.

Section 21.2 Eligibility. All bargaining unit employees who have at least one (1) year of Company service and who are involuntarily laid off from the Company (including such employees who *accelerate their layoff dates and employees laid off because of declining an offer for less than* equivalent employment as defined by Company policy) are eligible to receive the benefit described in 21.3; provided, however, the following employees shall not be eligible for the benefit: employees who volunteer for layoff; employees who upon their layoff become employed by a subsidiary or affiliate of the Company; employees who are laid off from the Company because of a merger, sale or similar transfer of assets and are offered employment with the new employer; employees who are laid off because of an act of God, natural disaster or national emergency; employees *who are laid off because of a strike, picketing of the Company's premises, work stoppage or any* similar action which would interrupt or interfere with any operation of the Company; and employees who terminate employment for any reason other than layoff, including, but not limited to, resignation, dismissal, retirement, death, or leave of absence. During times of significant surplus, the Company *may, at its discretion, provide layoff benefits as described in 21.3 to employees who volunteer for* layoff.

Section 21.3 Amount and Payment of Benefit. An eligible employee's total lump sum or income continuation benefit shall equal one (1) week of pay (i.e., forty (40) hours at the employee's base salary, but excluding any shift differentials or other premiums) for each full year of Company service as of the employee's layoff date, subject to a maximum benefit of 26 weeks of pay. Eligible employees may elect either of the following:

21.3(a) Benefits will be paid as a lump sum following the effective date of layoff. Employees who elect this option will have first consideration recall rights under Article 8 canceled.

21.3(b) Income continuation benefits will be paid in 80 hour increments, subject to an employee's total benefit, on regular paydays beginning with the second payday following the effective date of layoff. Income continuation benefits shall immediately cease upon the earlier of any of the following events: exhaustion of the employee's total income continuation benefit; re-employment with the Company or any of its subsidiaries or affiliates; failure to accept a formal offer of recall from layoff within ten (10) workdays after it is extended or by such later date as may be stipulated by the Company (provided such offer is for a position that is substantially equivalent to the position from which the employee was laid off); failure to report to work on the date designated by the Company; or change in the employee's employment status from layoff to resignation, dismissal, retirement, death, or leave of absence.

21.3(b)(1) Subject to continuation of the Plan, no employee shall be paid income continuation benefits more than once during any three (3)-year period; provided, however, if an employee is re-employed by the Company before payment of the employee's total income continuation benefit and is subsequently laid off in such three (3)-year period under conditions which make the employee eligible for a benefit, any unused benefit will be payable to the employee under the procedures established by this Article.

Section 21.4 Benefit Not Applicable for Other Purposes. Periods for which an employee receives income continuation benefits shall not be considered as compensation or service under any employee benefit plan or program and shall not be counted toward Company service. Benefits under this Article may not be deferred into the Voluntary Investment Plan.

Section 21.5 Continuation of Medical Coverage. In the event of layoff, medical coverage for employees and dependents will continue until the employee is covered by any other group medical plan either as an employee or as a dependent, but in no event beyond three (3) months after the date of layoff. Required contributions, if any, must be paid during any period of such continuation of coverage.

ARTICLE 22
JOB CLASSIFICATIONS

Section 22.1 Job Classifications System.

22.1(a) The Company will maintain a job classification system. In the system each occupation, job family, and authorized level shall be identified with an occupation description, job family description, and level guide. Each skills management code shall be identified with a skills management code description. The definitions of the elements of the system are as follows:

22.1(a)(1) Occupations, which are the broadest categories of work.

22.1(a)(2) Job families, which describe the organization of tasks.

22.1(a)(3) Level guides, which identify various levels of responsibility within the job family.

22.1(a)(4) FLSA code, which identifies the status of the job relative to the Fair Labor Standards Act.

22.1(a)(5) *Skills* management codes, which identify unique knowledge, skills, abilities, and environments within the job family.

22.1(b) A job classification is the combination of the occupation code, job family code, FLSA code, and level.

22.1(c) *The Union will participate in the identification, evaluation and review of all proposed* changes to job classifications in two ways. First, the union will have a member on the Company SJC *Maintenance Review Board. Second, the local Contract Administrator may bring forward job* classification issues to the local Company Compensation organization for resolution at the level *and/or for resolution through the Company SJC Maintenance process.*

22.1(d) The Company may add elements to, delete elements from, or modify any element of the job classification system.

Section 22.2 Classification of Employees. It is a mutual objective of the Union and the Company that the Job Classification and Skills Management Code of each employee be an accurate and timely reflection of the work assigned; however, the Company shall retain the exclusive right to assign or change the Job Classification or Skills Management Code of an employee. The Company may from time to time assign an employee work of a higher or lower level and work outside of his or her Job Classification or Skills Management Code. Any work assignment may include:

22.2(a) Teaching, instructing, leading or providing assistance to others.

22.2(b) The use of equipment to facilitate the work assignment.

22.2(c) The submission of completed work or any portion thereof for checking or approval.

22.2(d) The reporting of any work impairment such as errors in materials, processes, equipment, etc.

Section 22.3 Individual Employee's Job Classification or Skills Management Code Review. An individual employee may request a review of his or her job classification or level based on the contention the work assigned by the Company differs from the job classification or skills management code to the extent and in such a manner as to warrant reclassifying the employee to a different existing job classification or skills management code. Employees will attempt to resolve classification first by discussion with first-line management. In the absence of a resolution mutually agreeable to both management and the employee, the following steps will be utilized in the review process:

22.3(a) If the employee contends that a classification or level issue still exists, he or she along with his or her Union Representative will notify the Totem and/or Skill Team Manager to request a review.

22.3(b) The Totem and/or Skill Team Manager will meet with the employee and the Union Representative to fully discuss the employee's issue in an effort to reach mutual resolution.

22.3(c) If the employee and Union Representative do not agree with the Totem and/or Skill Team decision, the Totem and/or Skill Team Manager, the appropriate Human Resources Representative and the Union Representative will meet to resolve the matter by a majority decision.

Section 22.4 Reclassification to a Lower Level at Employee's Request or in Lieu of Layoff.

22.4(a) The Company may at the employee's request effect a reclassification to a lower level.

22.4(b) The Company may offer an employee a reclassification to a lower level in lieu of layoff.

Section 22.5 The provisions of Article 22 are not subject to the grievance and arbitration procedure in *Article 3.*

ARTICLE 23
DURATION

Section 23.1 Duration.

23.1(a) This Agreement shall become effective upon ratification, and shall remain in full force and effect until the close of February 19, 2008, and shall be automatically renewed for consecutive periods of one (1) year thereafter, unless either party shall notify the other in writing, at least sixty (60) days and not more than ninety (90) days prior to February 19 of any calendar year, beginning with 2008, of its desire either (1) to amend this Agreement, or (2) to terminate this Agreement as of a date stated in such notice to terminate, which date shall be subsequent to such February 19 provided that, in any event, this Agreement shall expire at the close of February 19, 2013.

23.1(b) If either a notice to amend or a notice to terminate is timely given pursuant to 23.1(a), the parties agree to meet within thirty (30) days thereafter for the purpose of negotiating an amendment to this Agreement or a new contract.

23.1(c) If a notice to amend is timely given pursuant to (1) of 23.1(a), either party may at any time thereafter notify the other in writing of its desire to terminate this Agreement as of a date stated in such notice to terminate, which date shall be subsequent to February 19 of the year in which such notice to amend is timely given and at least sixty (60) days subsequent to the giving of such notice to terminate.

23.1(d) This Agreement and any amendment thereof pursuant to this Article shall continue in full force and effect until either (1) a new contract superseding it is consummated, (2) it is terminated by a notice to terminate timely given pursuant to (2) of 23.1(a) or 23.1(c), or (3) it expires, whichever shall first occur.

23.1(e) Upon mutual written agreement of the parties, this agreement may be amended or terminated at any time prior to February 19, 2008.

Signed at Wichita, Kansas, and dated this 25th day of October, 2004.

Society of Professional Engineering Employees in Aerospace

By Jennifer MacKay

Jennifer MacKay
President

The Boeing Company

By

Jeffrey V. Clarke
Senior Manager, Employee & Union Relations

Attachment 1

LETTER OF UNDERSTANDING RELATING TO CASH PAYMENT

The Company agrees to pay employees covered by this agreement and on the active payroll or on leave of absence for ninety (90) days or less on both February 19, 2004, and on the date of the ratification of this agreement, a lump sum payment of eighteen hundred dollars ($1,800) less applicable withholding if this agreement is ratified on or before July 12, 2004.

The payment will be made two (2) weeks after ratification of this agreement.

Incentive Plan

The Company and the Union have both stated their interest in establishing an incentive plan for the WTPU bargaining unit. However, they understand that developing such a plan is difficult. Therefore, the parties agree to establish a joint committee to develop an incentive plan for the WTPU unit for years two, three and four of this collective bargaining agreement (2005, 2006 and 2007). This joint committee shall review incentive plans within Boeing and outside of Boeing in an effort to reach an agreement on a plan that will establish goals, which if met, will provide incentive pay for members of the unit.

The Joint Incentive Plan Committee shall consist of up to four (4) persons representing the Company and four (4) persons representing the Union. Each party shall appoint a chairperson of its group.

Any information regarding incentive plans at Boeing will be provided at the Company's discretion if the Company deems it necessary and appropriate for review. The Joint Incentive Plan Committee may necessarily be required to execute a confidentiality agreement before such information is provided.

The parties will jointly select and retain an independent consultant to assist in the development of the incentive plan. Said consultant will be mutually agreed to by the Company and the Union. The consultant's fees shall be paid by the Company.

The Joint Incentive Plan Committee shall meet as often as its members agree. The Company and the Union Chairpersons will establish committee meeting locations, agendas and procedures. The Committee will complete its work and present a joint recommendation for an incentive plan to the Union and the Company by December 1, 2004. The parties understand that any incentive plan must have the approval of the Board of Directors of the Boeing Company. Any plan agreed upon by the Committee will be submitted to appropriate executive officers for review, and then to the Boeing Board of Directors at their next regularly scheduled meeting.

It is understood that developing a mutually agreeable plan may be difficult. Therefore, if the Joint Committee is unable to develop a plan that is agreeable to both parties, then the members of the bargaining unit who are on the active payroll or on an approved leave of absence on November 30, 2005, will receive a one-time cash payment in December 2005 of one percent (1%) of an employee's bargaining unit gross earnings during the period from December 1, 2004, through November 30, 2005, less applicable withholding.

The parties agree that any incentive plan developed by the Committee will contain the following conditions:

1. The plan will allow employees to receive an incentive bonus of 0% to 5% each year for years two, three and four of the bargaining agreement. The plan shall have a 2.5% target if the basic goals of the plan are met.

2. The bonus will be calculated upon each eligible employee's gross salary for a consecutive twelve (12)-month period as detailed in the plan.

To create a proper environment for the committee's work, no aspect of the Committee's proceedings or any aspect of this Letter of Understanding shall be used as the basis for, or as evidence in, any proceedings under Article 3.

Dated October 25, 2004

Society of Professional Engineering Employees in Aerospace

By Jennifer Mackey
President

The Boeing Company

By
Senior Manager, Employee & Union Relations

Attachment 2

LETTER OF UNDERSTANDING RELATING TO CHILD/ELDER CARE PROGRAM

The Company will continue a comprehensive child and elder care program. The program will consist of referrals of employees to licensed care facilities, consultation with employees to determine individual needs, and providing educational materials and programs.

Dated October 25, 2004

Society of Professional Engineering Employees in Aerospace

By Jennifer Mackey
President

The Boeing Company

By
Senior Manager, Employee & Union Relations

Attachment 3

LETTER OF UNDERSTANDING RELATING TO DRUG AND ALCOHOL FREE WORKPLACE PROGRAM

The Company and the Union enter this Letter of Understanding to address the serious societal problem of drug and alcohol abuse. The Company and the Union affirm their joint objective to achieve a drug and alcohol free workplace while complying with applicable government laws and regulations. To that end, the parties agree to a drug and alcohol free workplace program as described in PRO-388.

The Company will continue its drug and alcohol awareness program designed to keep employees informed of the drug and alcohol free workplace program, including opportunities for professional assistance through the EAP, the dangers of drug and alcohol abuse, and drug and alcohol testing.

The Company will maintain a drug and alcohol free workplace training program for its managers, medical professionals, and other selected employees. Union selected individuals, including but not limited to the Union's Executive Board, Council Representatives, and staff members, will be invited to participate in training. Once a year the Union will provide the Company with a list of those persons to be trained.

The Company will implement a drug and alcohol testing program designed to deter abuse and to provide a means for early identification, referral for treatment, and rehabilitation of employees with abuse problems. The Company will at all times comply with its policy and procedures and with applicable government laws and regulations designed to safeguard the accuracy and reliability of drug and alcohol testing and to protect the confidentiality of those tested.

For reasonable suspicion and post-accident testing only, the employee has the right to request the presence of a Union Representative at the collection site. The Union Representative shall not in any way interfere

with or otherwise obstruct the collection process. The parties agree that the collection may be delayed a reasonable period, not to exceed thirty (30) minutes, to await the arrival of the Union Representative. The thirty (30)-minute period will commence when the Union, to include a Union Representative, is notified.

The Union reserves the right to grieve and arbitrate the question of whether the Company's program is consistent with the terms described in this letter.

Dated October 25, 2004

Society of Professional Engineering Employees in Aerospace

By Jennifer Mackay

President

The Boeing Company

By

Senior Manager, Employee & Union Relations

Attachment 4

LETTER OF UNDERSTANDING RELATING TO WORK ENVIRONMENT AND HEALTH AND SAFETY

The Company and the Union recognize their mutual concern for the health and safety of employees; for the free flow of information to and from both parties and Company employees regarding issues of safety, health, and the use and handling of hazardous materials and equipment in the workplace; and for the physical conditions under which the work is performed.

The parties' longstanding commitment to individual employee safety and regulatory compliance extends to issues regarding personal protective equipment and safety devices and the value of working together to create an injury-free workplace. To further this commitment, the parties have agreed to develop a process that will provide employees up to $75 per year towards the purchase of steel-toed safety shoes where such shoes are mandatory due to regulatory compliance or Company directive. Reimbursement will take place through the Company's check request process by submitting forms to the employee's immediate management for approval.

In addition, the Company agrees to present the Union, annually at their request, a review of current issues regarding the physical work environment and the activities of the Corporate Safety, Health and Environmental Affairs (SHEA) organization. The Union may request additional Meetings in order to address its concerns. The agenda for each meeting shall be agreed to by both parties in advance of such meetings.

Dated October 25, 2004

Society of Professional Engineering Employees in Aerospace

By Jennifer Mackay

President

The Boeing Company

By

Senior Manager, Employee & Union Relations

Attachment 5

LETTER OF UNDERSTANDING RELATING TO DATA REPORTS

The Company will provide the data to the Union which is listed in the memorandum from the Company to the Union effective November 4, 2002, subject to such revisions in the future as may be made by

mutual agreement of the parties. Nothing herein is intended to waive any right the Union may have to receive additional data.

Dated October 25, 2004

Society of Professional Engineering Employees in Aerospace

By Jennifer Mackay

President

The Boeing Company

By

Senior Manager, Employee & Union Relations

Attachment 6

LETTER OF UNDERSTANDING RELATING TO PRINTING OF CONTRACTS

The parties agree, in the spirit of labor/management cooperation, that they will equally share the costs of printing the labor agreement.

Dated October 25, 2004

Society of Professional Engineering Employees in Aerospace

By Jennifer Mackay

President

The Boeing Company

By

Senior Manager, Employee & Union Relations

Attachment 7

LETTER OF UNDERSTANDING RELATING TO OVERSIGHT OF LABOR-MANAGEMENT COOPERATIVE INITIATIVES

The parties enter this Letter of Understanding to establish a joint committee to oversee labor management initiatives the parties undertake. These joint initiatives are intended to enhance and develop employees as the Company's key resource.

The Joint Union-Company Oversight Committee shall consist of up to four (4) persons representing the Company and four (4) persons representing the Union. The Company representatives will be appointed from Business Unit and Human Resources management. The Union representatives will include three (3) employees and the Union's Executive Director or designee. Each party shall appoint a chairperson of its group.

The Joint Oversight Committee may oversee initiatives:

- Monitoring and exploring developments in the areas of education and training, skill utilization and application, and career development as those link to emerging technologies including the Ed Wells Initiative and Technical Principal Program.

- Monitoring developments in the areas of use of compensatory time off, child and elder care, Drug and Alcohol Free Workplace Program, and the Employee Assistance Program.

- Exploring alternate forms of compensation and delivery methods, salary planning process, market relationships and compensation philosophy.

- Discussion groups on topics of mutual interest.

- Exploring healthcare costs and plan details.

- *Continuing development of Career Enhancement, including:*

  - Programs to provide employees the information, training, and opportunity to influence their career direction.

  - A program to provide a meaningful career alternative for those employees who choose to remain on a technically oriented career path (as opposed to a managerial track).

  - Coordination with related activities to maximize efficiency and involve appropriate people and viewpoints as required.

- Continuing review of the PRO-700 Transfer process. The Company and the Union recognize the mutual benefit of making it possible for employees to request a transfer to another type of work, organization or geographical location.

- Conducting briefings on the Company's plans for the introduction of new technological change that may affect employees, including schedules of introduction and areas of skill impacts.

- Planning, developing, implementing and evaluating pilot projects involving innovative approaches in the workplace aimed at improving the quality of work life and productivity.

- Reviewing on a quarterly basis, if requested, data regarding overtime worked by employees.

The oversight function will include: (1) establishing subcommittees to handle the initiatives; (2) reviewing, expanding where appropriate, and resolving issues related to ongoing initiatives; and (3) formulating future labor-management cooperative initiatives. The Company in its sole discretion will provide administrative staff and appropriate funding to support the initiatives.

The Joint Oversight Committee shall meet as often as its members agree, but in no event less than quarterly. The Company and Union chairpersons will establish committee meeting locations, agendas and procedures. To create a proper environment for the committee's work, no aspect of the committee's proceedings shall be used as the basis for, or as evidence in, any proceedings under Article 3.

Dated October 25, 2004

Society of Professional Engineering Employees in Aerospace

By Jennifer Mackay

President

The Boeing Company

By

Senior Manager, Employee & Union Relations

Attachment 8

LETTER OF UNDERSTANDING RELATING TO SHAREVALUE PROGRAM

The Company and the Union agree that all eligible represented employees may participate in the Boeing ShareValue Program (also known as the ShareValue Trust) for the duration of this Agreement. The parties agree that the Company's success depends upon the ability to return long-term value to the shareholders. The intent of this incentive program is to help inform employees about what makes a business run and produces shareholder value, and to allow employees to share in the results of their efforts to increase shareholder value.

Employees will be eligible to participate in accordance with the governing provisions of the ShareValue Program as set forth in the official Program documents. In the event of any conflict between this Letter of Understanding and the official ShareValue program documents, the official ShareValue Program documents will prevail in every case.

Eligible participants will proportionally share in a ShareValue Program distribution based on the number of months they were eligible to participate during any investment period falling within the term of this Agreement or any preceding Agreement that provided for their participation in the ShareValue Program.

Dated October 25, 2004

Society of Professional Engineering Employees in Aerospace

By Jennifer Mackay

President

The Boeing Company

By

Senior Manager, Employee & Union Relations

Attachment 9

LETTER OF UNDERSTANDING RELATING TO VIRTUAL OFFICE

The parties enter into this Letter of Understanding as a result of the implementation of the Virtual Office Program. Following is a summary of the general provisions of this Program as they apply to SPEEA-represented employees.

Aspects of the Virtual Office have proven to be a viable work option that, when appropriately applied, benefit both the Company and the individual. The Virtual Office provides a balance between the tasks that are the responsibility of each individual and the requirements of each team and group.

The Virtual Office is a cooperative agreement between the manager and the employee, not an entitlement, and is based on: (1) the needs of the job assignment, work group and the Company, and (2) the employee's past and present levels of performance and defined personal characteristics. Specifications related to cost, number of days per week, equipment, and participation criteria are not specified in Boeing policy. Each organization has the latitude to utilize and tailor the application of Virtual Office policy to best meet its needs according to requirements, skills, and responsibilities.

The employee's duties, obligations, responsibilities and conditions of employment with the Company remain unchanged. Employees remain obligated to comply with all Company rules, policies, practices and instructions. Participation in the Virtual Office Program 'Work at Home' element is entirely voluntary and may be terminated by the employee, his or her manager, or the Company at any time.

The detailed terms and conditions of this Program are covered in the Virtual Office Program procedure, PRO-497, which is subject to change at the Company's discretion. The parties intend that union-represented employees be eligible to participate in the Program to the same extent as non-union employees.

Disputes concerning the content of this Letter of Understanding shall not be subject to the grievance and arbitration procedure of Article 3. Nothing in this Letter waives any rights reserved in Article 2.

Dated October 25, 2004

Society of Professional Engineering Employees in Aerospace

By Jennifer Mackay

President

The Boeing Company

By

Senior Manager, Employee & Union Relations

Attachment 10

LETTER OF UNDERSTANDING
RELATING TO THE TRAVEL CARD PROCESS

The Company and the Union enter this Letter of Understanding to memorialize their agreement to continue to monitor the process of paying business travel expenses and their ongoing mutual commitment for improvements in the same.

In addition to the terms and conditions defined by the Company, the following provisions continue to apply to the travel card process:

1. Employees will not be required to pay the card company for authorized business expenses before receiving payment from Travel Accounting so long as the delay in receiving that payment is due to the Company's neglect of factors outside the employee's control.

2. If, due to obvious employee neglect, payment to the card company is not made within sixty (60) days of receiving the invoice, the employee will be responsible for paying a 2.5 percent fee plus $10. The Company will pay any such fees that are incurred due to its neglect or because of process delays outside the employee's control. Any dispute over the imposition of such fees will be subject to Article 3.

3. In the event an employee has a disputed billing with the card company, the employee shall follow the guidelines for dispute resolution listed on the reverse side of the travel card invoice. The employee may contact Travel Accounting for assistance, and both will work cooperatively to resolve disputes.

4. Payment delinquencies will not be reported to a credit bureau unless the card company prevails in an action to collect the unpaid debt. Such legal action shall not commence unless the unpaid invoice is the employee's responsibility and the invoice has been left unpaid for over 180 days.

5. Authorized management may exempt employees who engage in extensive/frequent travel or for whom special circumstances exist from the decentralized billing process. Any employee shall be free to request an exemption.

6. The Company will take reasonable steps to preserve the confidentiality of the employee's personal and financial information related to the use of the travel card, and will use such information only for legitimate business reasons. Such information will not be used for solicitations for activities not related to Company travel.

Dated October 25, 2004

Society of Professional Engineering Employees in Aerospace

By Jennifer Mackay

President

The Boeing Company

By

Senior Manager, Employee & Union Relations

Attachment 11

LETTER OF UNDERSTANDING
RELATING TO FREQUENT FLIER MILEAGE

The Company agrees that frequent flier mileage and other travel-related benefits incurred while on Company business will be credited to personal employee accounts and may be applied towards personal travel. Employees must continue to comply with Company directives and Boeing Travel Office procedures

including those designed to minimize travel-related costs without regard to frequent flier mileage program considerations.

Dated October 25, 2004

Society of Professional Engineering Employees in Aerospace

By Jennifer Mackay

President

The Boeing Company

By

Senior Manager, Employee & Union Relations

Attachment 12

LETTER OF UNDERSTANDING RELATING TO SPEEA ACCESS TO THE BOEING WEB

The parties hereby agree that SPEEA shall have access to the Boeing internal Web page. To that effect, the parties agree as follows:

(1) SPEEA shall maintain the confidentiality of all information, data and computer programs ('Information Assets') to which SPEEA has access, along with any passwords or access procedures given to facilitate access to 'authorized SPEEA users'.

(2) SPEEA shall only access the Information Assets specified by the Boeing Computing Access Focal Point, and then only in accordance with the access procedures.

(3) SPEEA shall not access any other Information Assets not approved by the Boeing Computing Access Focal Point.

(4) SPEEA shall not remove any Information Assets from Boeing computing systems, or delete, change or otherwise modify any Information Assets.

(5) Access to Information Assets marked 'Boeing Limited' or bearing Government classified markings is strictly prohibited.

The Company may re-evaluate access at any time. Any decision by the Company to withdraw access shall not be subject to the provisions of Article 3.

Dated October 25, 2004

Society of Professional Engineering Employees in Aerospace

By Jennifer Mackay

President

The Boeing Company

By

Senior Manager, Employee & Union Relations

Attachment 13

LETTER OF UNDERSTANDING RELATING TO WORKING TOGETHER PARTNERSHIP

The parties acknowledge that a Working Together Partnership has been established between SPEEA and The Boeing Company in an agreement executed between SPEEA and The Boeing Company on December 6, 2002.

The primary mission of the Working Together Partnership is to identify agreed-upon areas where the Company, the technical workforce and the Union can work together to contribute to the success of SPEEA and the Company for their mutual benefit.

A Joint Policy Board has been established, comprised of an equal number of representatives of each party. Both the Company and SPEEA have appointed a representative from Wichita to the Board. In their participation the Wichita Representatives will consider the interests and concerns of the WTPU as well as the WEU. Any additional participation by the WTPU will be as required and deemed appropriate by the Board.

It is acknowledged that the Working Together Partnership includes allowing time during the new employee orientation of all new technical and professional employees' employment for them to meet with a SPEEA representative and learn about SPEEA's role in the Partnership.

Dated October 25, 2004

Society of Professional Engineering Employees in Aerospace

By Jennifer Mackay

President

The Boeing Company

By

Senior Manager, Employee & Union Relations

Attachment 14

LETTER OF UNDERSTANDING RELATING TO REVIEW OF SJC RATES

The Company agrees to annually review pay rates of the Salaried Job Classification system to ensure it continues to pay competitive salaries to technical and professional employees.

Dated October 25, 2004

Society of Professional Engineering Employees in Aerospace

By Jennifer Mackay

President

The Boeing Company

By

Senior Manager, Employee & Union Relations

Attachment 15

LETTER OF UNDERSTANDING RELATING TO AOG ASSIGNMENTS

Non-exempt employees on emergency field assignments relating to customer's airplane on ground (AOG) involving overnight travel from their home location to a location where the Company has not established an operation, and when such travel is covered by the Company's Business Travel procedures, shall not be subject to the provisions of Section 11.2.

The employee's work schedule status will be as follows:

(1) No shift identification will be assigned.

(2) Monday through Friday will be designated as regular workdays.

(3) Saturday will be designated as the first day of rest and Sunday will be designated as the second day of rest.

Wage payment basis will be as follows:

(1) The employee shall receive at least eight hours pay for each regular workday on which the employee works or is available for work.

(2) The employee's regular rate shall include his or her base rate plus a weekend premium rate of $2.00 per hour.

(3) For time worked in excess of forty (40) through fifty-two (52) compensated hours in a work week on other than a second day of rest, the employee shall be paid one and one-half (1-1/2) times his or her base rate. For time worked in excess of fifty-two (52) compensated hours in a work week, the employee shall be paid at double his or her base rate.

(4) For time worked on the second day of rest and in excess of forty (40) compensated hours in a work week, the employee shall be paid at double his or her base rate.

(5) For Company holidays which occur during a travel assignment employees shall receive eight (8) hours' holiday pay and, in addition, for time worked on a holiday, the employee shall be paid at his or her regular rate for twice the hours worked.

The following telephone and laundry allowance will be authorized:

(1) An employee will be authorized to telephone his home at Company expense in accordance with applicable Company policy. When necessary to use conventional long-distance service, the employee will be reimbursed for the cost of the call, provided the call is of reasonable duration.

(2) An employee on a travel assignment will be reimbursed for the cost of any laundry service which is reasonable and necessary in accordance with applicable Company policy.

Employees returning from such a travel assignment will be allowed twelve (12) hours between time of arrival at the home terminal, or clearance from U.S. Customs at the home terminal in the case of employees returning from international locations, and the start of their next regular shift assignment. Employees will be granted leave-with-pay for any un-worked portion of their assigned shift which falls within this twelve (12)-hour period provided they report for work at the applicable time so described in this provision. Exception to the above provision will be in the case where the twelve (12)-hour period extends beyond the end of the employee's regularly scheduled lunch period, in which case the employee will not be required to report for work and will be paid for the entire shift.

Employees on inter-continental travel assignments for which time enroute exceeds twelve (12) continuous hours will not be required to work their regular shift on the date of departure and will receive a minimum of eight (8) hours pay for that day. When travel time enroute to a customer work location exceeds twelve (12) continuous hours, a minimum of twelve (12) hours rest will be provided prior to beginning work whenever possible within customer required schedules.

Dated October 25, 2004

Society of Professional Engineering Employees in Aerospace

By Jennifer Mackay

President

The Boeing Company

By

Senior Manager, Employee & Union Relations

Attachment 16

LETTER OF UNDERSTANDING
RELATING TO MANAGEMENT RIGHTS

It is understood by the parties that the Rights of Management as detailed in Article 2 include the Company's exclusive right to reorganize, transfer, contract or subcontract out, sell, discontinue, or relocate any or all of the operations of the business, including but not limited to work being scheduled to be performed by employees in this unit, which right shall not be subject to the grievance and arbitration procedure of this Agreement. Nothing herein waives the Union's right to negotiate the effects of management unilateral decisions as noted above on the terms and conditions of employment of unit members. The Company agrees that it will notify the Union before any major change is made which would significantly affect the Unit.

The Company and the Union agree that due to the nature of the work performed by employees represented by the Union, managers may, from time to time, perform work that would otherwise be performed by bargaining unit members. Likewise, the Company and the Union agree that the professional employees and certain employees due to the confidential nature of their work, both of whom are identified in Article 1, are not included within the jurisdictional unit represented by the Union and that the work performed by these confidential and professional employees may be similar to work otherwise performed by these unit members. The Company retains the right to make work assignments to such employees and the Company's actions in doing so shall not be subject to the grievance and arbitration procedure of this Agreement.

Dated October 25, 2004

Society of Professional Engineering Employees in Aerospace

By Jennifer Mackay

President

The Boeing Company

By

Senior Manager, Employee & Union Relations

Attachment 17

LETTER OF UNDERSTANDING
RELATING TO SEX CRIMES

The Company and the Union recognize (1) the growing awareness and abhorrence in our society of sex crimes victimizing children, and (2) the deleterious effect the presence in the workforce of perpetrators of such crimes would have on the efficiency and morale of professional/engineering and technical employees of the Company and on the reputation of the Company and its products. The parties therefore agree as follows:

(1) Any discipline or discharge of a Union-represented employee who has committed a sex crime victimizing a child or children shall be deemed to be for "just cause" and shall not be subject to the grievance and arbitration provisions of the parties' collective bargaining agreements or to any other challenge or proceeding by the Union.

(2) For purposes of this Letter of Understanding, the term "sex crime victimizing a child or children" includes rape, sexual assault, statutory rape, incest, child molestation, child pornography, public indecency, indecent exposure, indecent liberties, communications with a minor for immoral purposes, promoting prostitution, and similar crimes as defined in the jurisdiction in which the offense is committed, where the victim of said crime(s) is under the age of 18 years at the time of the commission of the crime(s). An employee shall be considered to have committed such a crime if the employee is convicted of the crime, or if the employee pleads guilty or nolo contendere to the crime, or if the employee enters a special supervision program pursuant to a deferred prosecution arrangement relating to the crime.

(3) The provisions of this Letter of Understanding shall not be deemed to define "just cause" or to affect the grievance and arbitration provisions in any other respect whatsoever, nor shall it be introduced or relied upon in any arbitration or other proceeding involving the parties which does not deal with the discipline or discharge of an employee who has committed a sex crime victimizing a child or children.

Dated October 25, 2004

Society of Professional Engineering Employees in Aerospace

By Jennifer Mackay

President

The Boeing Company

By

Senior Manager, Employee & Union Relations

APPENDIX A

ORGANIZATIONS/FUNCTIONS WITH CONFIDENTIAL EMPLOYEES AND CURRENT JOBS IDENTIFIED AS CONFIDENTIAL

A. CONFIDENTIAL GROUP 1 – PERSONNEL INFORMATION

1. People Organization/People Systems excluding Trainers and Health Services Administrators

- FADU – HUMAN RESOURCE GENERALIST
- FADV – HUMAN RESOURCE SPECIALIST
- UAWL – OFFICE ADMINISTRATOR CONFIDENTIAL
- BDAW – APPLICATIONS ANALYST
- BDAU – PROGRAM/ANALYST - BUSINESS
- 9AWE – BUSINESS AND PLANNING ANALYST CONFIDENTIAL

2. Employee Assistance Program

- 7BTW – EMPLOYEE ASSISTANCE PROGRAM ADMINISTRATOR

3. Law and Ethics

- CABN – COUNSEL
- UAMX – ADMINISTRATIVE ASSISTANT
- SAMT – ETHICS ADVISOR

4. Security & Fire Protection

- BCBH – DESKTOP SYSTEMS INSTALLER
- BACS – COMPUTING SECURITY SPECIALIST
- LAHQ – INDUSTRIAL SECURITY SPECIALIST
- LAHR – ACCESS ADMINISTRATOR
- LAHS – INVESTIGATOR
- LAHW – S & FP MULTIPLE OPERATIONS SPECIALIST
- LAHT – UNIFORMED SECURITY OFFICER
- UAWL – OFFICE ADMINISTRATOR

B. *CONFIDENTIAL GROUP 2 – BUSINESS INFORMATION*

1. Program Management Office

- 2AGP – WRITER/EDITOR
- KADN – MARKETING AND SALES REPRESENTATIVE
- KADQ – STRATEGY & ANALYSIS SPECIALIST
- KADS – CUSTOMER RELATIONS SPECIALIST
- KADT – MARKETING AND SALES PROCESS SPECIALIST
- UAMC – PROGRAM MANAGEMENT SPECIALIST
- WASV – PROGRAM MANAGEMENT SPECIALIST (P & L)
- UAWL – OFFICE ADMINISTRATOR CONFIDENTIAL
- UAMX – ADMINISTRATIVE ASSISTANT
- UANR – STAFF ANALYST

2. Internal Audit

- 9AHL – INTERNAL AUDITOR

3. Communications & Public Affairs and State & Local Government Relations

- 2AGR – GRAPHIC ARTIST
- 4ADL – COMMUNICATIONS SPECIALIST
- MACU – COMMUNITY RELATIONS SPECIALIST

- MACV – EDUCATION RELATIONS SPECIALIST
- MACX – GOVERNMENT RELATIONS SPECIALIST
- UAWL – OFFICE ADMINISTRATOR CONFIDENTIAL
- UAMX – ADMINISTRATIVE ASSISTANT
- UANR – STAFF ANALYST

4. **Finance**
   - 9AWC – ACCOUNTANT CONFIDENTIAL
   - 9AWE – BUSINESS AND PLANNING ANALYST CONFIDENTIAL
   - 9AHN – TAX SPECIALIST
   - 9AWG – ESTIMATING AND PRICING SPECIALIST CONFIDENTIAL
   - 9AHK – INSURANCE/RISK MANAGEMENT ANALYST
   - 9ARA – PROPERTY MANAGEMENT SPECIALIST
   - 5AAD – CONTRACTS & PRICING ADMINISTRATOR (Levels 4 & 5)
   - 5AAE – EXPORT ADMINISTRATOR
   - 5AAH – IMPORT ADMINISTRATOR
   - 5AMS – COMMERCIAL A/C CONTRACTS ADMINISTRATOR

5. **Executive Office Administrators**
   - UAWL – OFFICE ADMINISTRATOR CONFIDENTIAL

C. CONFIDENTIAL GROUP 3 – INFORMATION TECHNOLOGY

1. **Systems Level Root Authority**
   - BCWD – SYSTEM DESIGN & INTEGRATION SPECIALIST CONFIDENTIAL
   - BDBA – DATABASE ADMINISTRATOR

ATTACHMENT A

SOCIETY of PROFESSIONAL ENGINEERING EMPLOYEES in AEROSPACE
(Wichita Technical and Professional Unit)

GROUP BENEFITS PACKAGE

- Life Insurance
- Accidental Death and Dismemberment
- Medical
- Dental

TABLE OF CONTENTS

The Package

THE PACKAGE INCLUDES:

- Life Plan
- Medical Plans
- Accidental Death and Dismemberment Plan
- Dental Plans

SECTION 1
ELIGIBLE EMPLOYEES

Employees eligible for the Package are active Boeing salaried employees represented by the Society of Professional Engineering Employees in Aerospace ('SPEEA'). The employee is not eligible to enroll if he or she is working in a capacity that, at the sole discretion of the *plan administrator,* is considered contract labor or independent contracting.

SECTION 2
ELIGIBLE DEPENDENTS

Dependents eligible for the medical and dental plans are the employee's legal spouse and children (natural children, adopted children, children legally placed with the employee for adoption, and stepchildren) who are under age 25, unmarried, and dependent on the employee for principal support, including children who are attending school.

An employee may request coverage for the following dependents:

1. A common-law spouse if the relationship meets the common-law requirements for the state in which the employee entered into the common-law relationship.

2. A same-gender domestic partner if the employee and same-gender domestic partner meet all of the following requirements. The employee and partner must be:

   a. Of the same gender.

   b. Eighteen years of age or older.

   c. Financially interdependent and share the same residence.

   d. Not married to or legally separated from another person or involved in another same-gender domestic partner relationship.

   e. Not blood relatives of a degree of closeness that would prohibit marriage.

   A same-gender domestic partner is considered a spouse for the purpose of the medical and dental plans. The employee must complete an Affidavit of Domestic Partnership to cover a same-gender domestic partner under the medical and dental plans.

3. Unmarried children of the employee's same-gender domestic partner who are under age 25. These children are considered stepchildren for the purpose of the medical and dental plans. The Affidavit of Domestic Partnership requirement applies.

4. Other children, as follows, who are under age 25, unmarried, and dependent on the employee for principal support, including children who are attending school:

   a. Children who are related to the employee either directly or through marriage (e.g., grandchildren, nieces, nephews).

   b. Children for whom the employee has legal custody or guardianship, or has a pending application for legal custody or guardianship, and are living with the employee.

Annual certification of eligibility is required to continue coverage for children from age 19 through age 24.

In accordance with federal law, the Company also provides medical and dental coverage to certain dependent children (called alternate recipients) if the Company is directed to do so by a qualified medical child support order (QMCSO) issued by a court or state agency of competent jurisdiction.

Documentation is required to request coverage for a child named in a QMCSO, for a child for whom the employee has been given legal custody or guardianship or for a same-gender domestic partner or his or her children.

A. Special Provisions When Family Members Are Boeing Employees. No person may be covered both as an employee (active or retired) and as a dependent under any type of plan offered by Boeing, and no person will be considered a dependent of more than one employee. Eligible dependents do not include other Boeing employees covered under any *Company-sponsored plan* providing medical, vision care, prescription drug, dental, or similar services. However, if a dependent spouse is also a part-time Boeing employee, the spouse and eligible dependent children are considered eligible dependents if other Boeing coverage is waived. If the employee and spouse both are Boeing employees and have dependent children, the parents may elect medical and dental coverage for eligible children under one parent's plans. As an alternative, parents may elect medical coverage for eligible children under one parent's plan and dental coverage under the other parent's plan. In either case, all eligible children must be enrolled in the same medical plan and the same dental plan (except as required by a QMCSO). The same provisions apply to a same-gender domestic partner and his or her children.

B. Incapacitated Children. A disabled child age 25 or older may continue to be eligible (or enrolled if the employee is a newly-eligible employee) if he or she is incapable of self-support due to any mental or physical condition that began before age 25. The child must be unmarried and dependent on the employee for principal support. Coverage may continue under the medical and dental plans for the duration of the incapacity as long as the employee continues to be eligible under the plans and the child continues to meet these eligibility requirements.

Special applications for coverage are required for disabled dependent children age 25 or older.

SECTION 3
HOW TO ENROLL

A. Life Insurance and Accidental Death and Dismemberment Plans. Employees automatically are enrolled in the Life Insurance and Accidental Death and Dismemberment Plans when eligible. The employee may designate a beneficiary for life and accident benefits through the Boeing Service Center.

B. Medical Plans. In designated locations, the Company provides employees with a choice among medical plans. The Traditional Medical Plan offers enhanced benefits when a member of its *network* is used. Coordinated care plans also rely on selected *networks* of *providers.*

Employees receive enrollment instructions at the time of employment and may elect medical coverage *under one medical plan by the date indicated on the enrollment worksheet.* All family members, including the employee, must be enrolled in the same medical plan, except as specified in Section 2.A.

The Company provides medical coverage as follows:

1. Employees who live or work in a coordinated care plan service area may enroll in a coordinated care plan or the Traditional Medical Plan.

2. Employees who do not live or work in a coordinated care plan service area may enroll in the Traditional Medical Plan.

Some coordinated care plans do not offer same-gender domestic partner coverage.

3. Each employee with a spouse (or same-gender domestic partner) enrolled in a *Company-sponsored plan* must provide information regarding coverage available through another employer to determine whether or not special contributions are required to enroll the spouse. If the employee does not authorize a required contribution, the spouse will not be enrolled for medical coverage. The employee will not be able to enroll the spouse until the earlier of:

   a. The next annual enrollment period.

   b. The date the spouse loses the option to be covered under the other employer-sponsored medical plan.

The Company will require periodic verification of data.

C. Dental Plans. Employees in certain areas are offered three (3) dental plans: the Scheduled Dental Plan, Preferred Dental Plan, and Prepaid Dental Plan. In certain areas, *provider networks* for the Preferred Dental Plan and/or Prepaid Dental Plan may not be available and employees are offered only the Scheduled Dental Plan. Employees receive enrollment instructions at the time of employment and may elect dental coverage under one dental plan by the date indicated on the enrollment worksheet. All family members, including the employee, must be enrolled in the same dental plan except as specified in Section 2.A.

The Company provides dental coverage as follows:

1. The Company provides coverage under the Scheduled Dental Plan, Preferred Dental Plan, or Prepaid Dental Plan for employees who live in a service area of the Preferred Dental Plan or Prepaid Dental Plan.

   Under the Prepaid Dental Plan, employees must select a *participating provider* from the prepaid *provider network.* No dental benefits are payable until the employee selects a *participating provider.*

2. The Company provides dental coverage under the Scheduled Dental Plan to employees who do not live or work in a service area of the Preferred Dental Plan or Prepaid Dental Plan.

D. Annual Enrollment Period. The Company establishes an annual enrollment period when employees may change medical and/or dental plans.

E. Special Enrollment. If an employee declines dependent enrollment in the medical and dental plans because of other employer-sponsored health care coverage (such as through a spouse's employer), the employee may be able to enroll eligible dependents in the *Company-sponsored* medical and dental plans during the year as long as enrollment is within sixty (60) days after other coverage ends.

If an employee declines dependent enrollment when first eligible and the dependent's other health care coverage was through continuation coverage from a previous employer (coverage mandated by the Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA), the dependent must exhaust his or her COBRA coverage to be eligible for the special enrollment period.

If a dependent's other health care coverage was not through COBRA, the coverage loss must be due to loss of eligibility for the health care coverage (including from divorce, death, termination of employment, or reduction in hours of employment) or termination of employer contributions toward such coverage.

If an employee has a new dependent as a result of marriage, entering into a same-gender domestic partner relationship, birth, adoption, or placement for adoption, the employee may enroll the new dependent during the year as long as enrollment is requested within one hundred twenty (120) days after the qualified event. See "Changes in Status," Section 3.F., for more information.

F. **Changes in Status.** An employee will not be able to make enrollment changes until the next annual enrollment period unless the employee experiences one of the qualified changes in status described in this section. Any change in enrollment must be consistent with the change in status. To be consistent, the event must cause the employee or family member to gain or lose eligibility for *Company-sponsored* employer health care coverage or health care coverage sponsored by a spouse's or dependent child's employer, and the election change must be on account of and correspond with the employee's or employee's family member's gain or loss of eligibility.

Qualified changes in status include the following:

1. The employee marries, divorces, or becomes legally separated, or the marriage is annulled.
2. The employee enters into or dissolves a same-gender domestic partner relationship.
3. The employee acquires a new, eligible dependent child, such as by birth, adoption, or placement for adoption.
4. The employee's spouse or dependent child dies.
5. The employee's spouse or dependent child starts or stops working.
6. The employee, spouse, or dependent child has any other change in employment status that affects eligibility for coverage such as changing from full time to part time (or part time to full time), salaried to hourly (or hourly to salaried), strike or lockout, or beginning or returning from a leave of absence.
7. The employee, spouse, or dependent child experiences a significant increase in the cost of employer-sponsored health care coverage or the employer-sponsored health care coverage ends, including expiration of COBRA coverage.
8. The employee, spouse, or dependent child experiences a significant curtailment or cessation of employer-sponsored health care coverage.
9. The employee, spouse, or dependent child becomes eligible or ineligible for Medicare or Medicaid.
10. The employee's dependent child becomes eligible for, or no longer is eligible for, health care coverage due to age limits, student status, or a similar eligibility requirement.
11. The employee's spouse or dependent child makes an enrollment change in his or her employer-sponsored health care coverage, either because of a qualified change in status or an annual enrollment.
12. The employee, spouse, or dependent child changes place of residence or work, affecting access to care within the current plan.
13. The employee is transferred to a different division, affecting eligibility for benefits under *Company-sponsored* health care plans.

The employee also may change an election to comply with a qualified medical child support order (QMCSO) to provide or cancel coverage for a child resulting from a divorce, annulment, or change in legal custody.

In most situations, the employee must request enrollment within sixty (60) days after the qualified event. An employee can enroll a new dependent within one hundred twenty (120) days following the employee's marriage or entering into a same-gender domestic partner relationship or a dependent child's birth, adoption, or placement for adoption. To request enrollment for a new dependent more

than sixty (60) days but within one hundred twenty (120) days after marriage, entering into a same-gender domestic partner relationship, birth, adoption, or placement for adoption, the employee must call the Boeing Service Center and speak with a customer service representative. In all cases, the employee must provide the Boeing Service Center with any required supporting documentation within thirty-one (31) days of the date the enrollment is requested or the coverage change request will be denied.

If the employee is enrolled in a coordinated care plan, HMO, Preferred Dental Plan, or Prepaid Dental Plan and moves out of the service area, the employee can enroll in a plan available in the new location by calling the Boeing Service Center.

SECTION 4
EFFECTIVE DATE OF COVERAGE

A. Employees. For newly hired employees, the Package becomes effective as follows:

1. Medical and dental coverage becomes effective on the first day of the month following the employee's first day of employment.

2. Life insurance and accidental death and dismemberment coverage becomes effective on the first day of the month following the employee's first day of employment, provided the employee is *actively at work* on that date.

To be an eligible employee in any subsequent calendar month, the employee must be on the active payroll on the first day of that month.

For coverage during a leave of absence, see Section 20.

An employee enrolled in medical coverage must make any required contributions.

B. Dependents. Current eligible dependents are covered for medical and dental benefits on the same date the employee's coverage is effective. Eligible dependents acquired after the employee's coverage is effective become covered on the date of marriage or entering into a same-gender domestic partner relationship, date of birth, or date the child is legally placed with the employee for adoption, if application is made within one hundred twenty (120) days of the event. For other newly eligible dependents, coverage is effective on the date dependency is established, if application is made within sixty (60) days of the event.

The employee authorizes required contributions when enrolling eligible dependents.

SECTION 5
COMPANY AND EMPLOYEE CONTRIBUTIONS

Company and employee contributions for the Group Benefits Package are described in Article 16 – Group Benefits.

SECTION 6
LIFE INSURANCE PLAN

The life insurance benefit is equal to two and a quarter (2-1/4) times the employee's base annual salary up to a maximum benefit of $500,000. The coverage amount is rounded to the next highest $1,000 if it is not already an even $1,000. The total amount is payable in the event of the employee's death from any cause at any time or place while covered. Payment is made in a lump sum or installments to the designated beneficiary. The employee may change beneficiaries any time by contacting the Boeing Service Center.

If the employee becomes permanently and totally disabled while covered and before age 60 from any cause, the life insurance benefit will remain in force, without cost to the employee, as long as the employee remains disabled. If an employee becomes permanently and totally disabled between ages 60 and 65, the life insurance benefit will be continued without premium payment until the earlier of the employee's recovery or attainment of age 65. Proof of disability must be furnished within twelve (12) months of the date active work ends.

The disability must have existed continuously for six (6) months and be expected to keep the employee, for life, from performing any work for compensation or profit.

If the employee recovers but does not return to work, all coverage terminates. The employee may then convert the total amount of the life insurance benefit under the conversion of benefits provision.

SECTION 7
ACCIDENTAL DEATH AND DISMEMBERMENT PLAN

Accidental death and dismemberment benefits are paid if the employee's loss of life, paralysis, or loss of limbs, eyesight, speech, or hearing is caused by a covered accident (including an occupational accident) that occurs while the employee is covered under the Plan.

The full principal sum, $25,000, is paid to the beneficiary if the employee dies. This amount is in addition to any amount payable under the Life Insurance Plan.

The following benefits are payable if the covered injury causes any of the following losses within 365 days after the covered accident:

Loss of	Percentage of Principal Sum
Life	100%
Quadriplegia	100%
Both Hands or Both Feet	100%
Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and the Sight of One Eye	100%
One Foot and the Sight of One Eye	100%
Speech and Hearing in Both Ears	100%
Paraplegia	75%
Hemiplegia	50%
One Hand or One Foot	50%
Sight of One Eye	50%
Speech or Hearing in Both Ears	50%
Hearing in One Ear	25%
Thumb and Index Finger of Same Hand	25%

"Loss" of a hand or foot means the complete severance through or above the wrist or ankle joint. "Loss" of sight of an eye means the total and irrecoverable loss of the entire sight in that eye. "Loss" of hearing in an ear means the total and irrecoverable loss of the entire ability to hear in that ear. "Loss" of speech means the total and irrecoverable loss of the entire ability to speak. "Loss" of a thumb and index finger means the complete severance through or above the metacarpophalangeal joint of both digits.

"Quadriplegia" means the complete and irreversible paralysis of both upper and both lower limbs. "Paraplegia" means the complete and irreversible paralysis of both lower limbs. "Hemiplegia" means the complete and irreversible paralysis of the upper and lower limbs of the same side of the body. "Loss" of a limb means the loss of an entire arm or entire leg.

"Injury" means bodily injury caused by an accident occurring while the employee is covered under the Plan, and resulting directly and independently of all other causes in death or loss as listed above.

If more than one loss is sustained by the employee as a result of the same accident, no more than one hundred (100%) percent of the principal sum will be paid.

If the employee is unavoidably exposed to the elements due to an accident occurring while covered under this Plan, and as a result of such exposure suffers a loss for which a benefit is otherwise payable, the loss will be covered under the terms of this Plan.

If the employee's body has not been found within one (1) year of the disappearance, forced landing, stranding, sinking, or wrecking of a vehicle in which he or she was an occupant while covered under this Plan, the loss will be covered as an accidental death under the terms of the Plan.

No Plan benefits will be paid for a death or loss caused in whole or in part by, or resulting in whole or in part from:

1. Suicide or intentionally self-inflicted injury.

2. Declared or undeclared war or act of declared or undeclared war occurring in the continental limits of the United States, unless it is an act of terrorism.

   "Terrorism" means any violent act that is intended to cause injury, damage, or fear and that is committed by or purportedly committed by one or more individuals or members of an organized group to make a statement of the individual's or group's political or social beliefs, concepts, or attitudes and/or to intimidate a population or government into granting the individual's or group's demands.

3. An illness, sickness, disease, bodily or mental infirmity, medical or surgical treatment or bacterial or viral infection, regardless of how contracted, except bacterial infection resulting from an accidental cut or wound or accidental food poisoning. However, if a covered loss results from medical or surgical treatment of an injury, benefits will be provided for the loss.

SECTION 8
CHANGES IN AMOUNT OF LIFE INSURANCE BENEFIT

If the employee's base annual salary is changed either upward or downward, the employee's amount of life insurance benefit automatically changes. The effective date of the change in benefit is the first day of the month coinciding with or following the date the Boeing Service Center is notified of the employee's change in salary. However, if the employee is not *actively at work* on such date, the effective date of the change in benefit is the first day of the month coinciding with or following the employee's return to active work. Any retroactive change in an employee's base annual salary is not applicable in determining the amount of life insurance benefit.

SECTION 9
MEDICAL PLANS – SCHEDULE OF BENEFITS

In designated locations, the Company provides employees with a choice among medical plans. The Traditional Medical Plan is a PPO plan that offers enhanced benefits when a member of its *provider network* is used. Coordinated care plans and health maintenance organizations (HMOs) also rely on selected *networks* of *providers*. Benefits are subject to all provisions of the selected plan, including medical review requirements, maximum benefits, coordination of benefits, exclusions, and definitions. If a coordinated care plan or HMO plan does not offer the negotiated plan design, the Company will substitute the closest available plan design.

A. Preventive Care Services. The following preventive care services are provided according to *network* guidelines:

1. Routine physical examinations for employees and spouses and routine screening examinations for employees and dependents.

2. Routine well-baby and well-child care, including periodic examinations, preventive immunizations, and inoculations as prescribed by a *physician.*

B. Covered *Medical Services and Supplies.* The plans provide benefits according to *network* guidelines for the following *medically necessary services and supplies* required for the diagnosis and/or therapeutic treatment of a non-occupational accidental injury or illness or medically necessary treatment of certain listed conditions.

1. *Physician* services, including office visits, consultation for a second or third opinion, surgery, and *hospital* visits. An initial chiropractic examination, including initial X-rays, is covered. Benefits for manipulation of the spine and the extremities are limited to twenty-six (26) visits each year.

2. Services provided by other licensed health care professionals.

   a. Diagnostic X-ray and laboratory services.

   b. Physical, occupational, and speech therapy to restore function. Services must be prescribed by a *physician.*

   c. *Neurodevelopmental therapy* for children age six or younger.

3. Medical equipment, services, and supplies.

   a. Ambulance services.

   b. Durable medical equipment.

   c. Hearing aids.

   d. Hemodialysis.

   e. Home medical equipment.

   f. Orthopedic appliances and braces.

   g. Oxygen and anesthesia.

   h. Prostheses.

   i. Radiation therapy (including X-ray therapy) and chemotherapy.

4. *Hospital services and supplies,* including semi-private room and board; operating rooms and equipment; surgical dressings and supplies; X-ray and laboratory services; anesthesia, including administration and materials; pathology; drugs; and outpatient *hospital* and emergency room services.

5. *Hospital* alternatives. Benefits for the following are provided in place of medically necessary hospitalization:

   a. Skilled nursing facilities.

b. Home health care.

c. Hospice care.

C. Special Conditions. Services are covered for the following conditions, according to *network* guidelines:

1. Cosmetic surgery for prompt repair of accidental injury.

2. *Mental illness* and *substance abuse.*

3. Oral surgery.

4. Pregnancy.

5. Reconstructive breast surgery in connection with a mastectomy.

6. Sterilization (vasectomy and tubal ligation).

7. TMJ and MPDS (coverage varies by *network).*

8. Transplants.

D. Vision Care. Vision care benefits are provided according to a schedule of benefits. The schedule varies by *network.*

E. Prescription Drugs. Prescription drug benefits vary by *network.*

SECTION 10
MEDICAL PLANS – PAYMENT PROVISIONS

Payment provisions under the plans follow.

A. Deductibles

Deductibles are expenses for certain covered *services and supplies* that the employee or family member must pay before benefits are payable.

Deductibles are subtracted from the total of all other submitted expenses for covered *medical services and supplies* before benefits are payable. Only expenses covered by a plan may be counted toward accumulation of deductibles.

Annual base wage, for the purpose of calculating deductibles, is the employee's annual base wage on July 1 of each year.

	Traditional Medical Plan	Coordinated Care Plans
1. Expenses subject to deductibles		
a. *Network providers*	All covered expenses (except those for *network provider* office, home, or *hospital* outpatient visits where the $15 co-payment applies, preventive care, vision care, mail service prescription drugs, and smoking cessation treatment) are subject to deductibles.	Covered expenses are not subject to deductibles. If the *network* plan requires that care be received from (or referred by) a primary care *physician*, then care not received from (or referred by) a primary care *physician* is considered a non-network service.
b. Non-network providers	All covered expenses (except those for preventive care, vision care, mail service prescription drugs, and smoking cessation treatment) are subject to deductibles.	All covered expenses (except those for emergency care) are subject to deductibles.
2. Deductible amounts		
a. Individual deductible		
1) *Network providers*	Each year a separate deductible applies to each covered person. The deductible applies only once in any year even though the person may have several different accidental injuries or illnesses. The individual deductible is the greater of $200 or 0.2 percent of annual base wage.	No deductible applies.
2) Non-network providers	*Network* deductible provisions also apply to non-network providers.	Each year a separate deductible applies to each covered person for non-network services. The deductible applies only once in any year even though the person may have several different accidental injuries or illnesses. The individual deductible is $400.
b. Family deductible		
1) *Network providers*	Each year, the Plan limits the deductible amounts applied to the employee's family to the greater of $600 or 0.6 percent of annual base wage. After the family deductible has been met, no further deductible is applied during that year to the employee or to the family members.	No deductible applies.

	Traditional Medical Plan	Coordinated Care Plans
Family deductible (cont.)		
2) *Non-network* providers	*Network deductible provisions* also apply to non-network providers.	*No family deductible limit* applies to non-network services.

B. Co-payments

	Traditional Medical Plan	Coordinated Care Plans
1. Emergency room co-payment	A $50 emergency room co-payment applies to each *hospital* emergency room visit. The emergency room co-payment does not apply if the patient: a) Is admitted to the *hospital* immediately following such treatment. b) Is treated in the emergency room for 12 or more hours. c) Dies in the emergency room. This emergency room co-payment does not apply toward the individual deductible, family deductible, or out-of-pocket expense limits.	A $50 emergency room co-payment applies to each *hospital* emergency room visit. If the patient is admitted to the *hospital* immediately following such treatment, the emergency room co-payment does not apply. (Other reasons for waiver of the co-payment vary by plan.) This emergency room co-payment does not apply toward the individual deductible, family deductible or co-payment provisions.
2. Office visit co-payment	A $15 co-payment applies to each covered outpatient visit to a *network physician* (except for preventive care, smoking cessation, mental health, and *substance abuse* services).	A $10 co-payment applies to each covered office visit to a *network provider.*
3. Prescription drug co-payments		
a. Retail Pharmacy	Covered prescriptions or refills are subject to the deductibles. The preferred pharmacy card program provides up to a thirty-four (34)-day supply.	A $5 co-payment applies to each covered generic prescription or refill obtained from a *network* pharmacy. A $15 co-payment applies to each covered brand-name *formulary* prescription or refill obtained from a *network* pharmacy. A $30 co-payment applies to each covered brand-name non-formulary prescription or refill obtained from a *network* pharmacy. These co-payment amounts provide up to a thirty-four (34)-day supply (supply varies by plan).

	Traditional Medical Plan	Coordinated Care Plans
b. Mail service prescription drug program	A $10 co-payment applies to each covered generic prescription or refill obtained from the *network's mail service prescription drug program.* A $30 co-payment applies to each covered brand-name *formulary* prescription or refill obtained from the *network's mail service prescription drug program.* A $60 co-payment applies to each covered brand-name non-formulary prescription or refill obtained from the *network's mail service prescription drug program.* These co-payment amounts provide up to a ninety (90)-day supply.	A *mail service prescription drug program* may not be available in all coordinated care plans. If a program is available, a $10 co-payment applies to each covered generic prescription or refill obtained from the *network's mail service prescription drug program.* A $30 co-payment applies to each covered brand-name *formulary* prescription or refill obtained from the *network's mail service prescription drug program.* A $60 co-payment applies to each covered brand-name non-formulary prescription or refill obtained from the *network's mail service prescription drug program.* These co-payment amounts provide up to a ninety (90)-day supply.
4. Vision examination co-payment	A $15 co-payment applies to each covered eye examination performed by a *network provider.*	Varies by plan.

C. Plan Payment Levels

Plan payment levels are subject to all provisions of the selected plan, including medical review requirements, maximum benefits, coordination of benefits, exclusions, and definitions.

After satisfaction of the deductible and co-payment requirements, the plans pay for covered *medical services and supplies* according to the following chart. (Payment levels for the coordinated care plans may vary from the schedule as required by applicable state law.)

	Traditional Medical Plan	Coordinated Care Plans
1. ***Network hospitals***	Covered services are paid in full when received from a *network hospital* that meets *patient safety standards.* Covered services are paid at ninety-five percent (95%) of the *allowed charge* when received from a *network hospital* that does not meet *patient safety standards.*	Covered services received from a *network hospital* are paid in full.

	Traditional Medical Plan	Coordinated Care Plans
Plan payment levels (cont.)		
2. Other *network providers*	Outpatient visits to a *network physician* are paid in full after a $15 co-payment, except as noted in Section 11.B.2.+ Other covered services of *network providers* are paid at ninety-five percent (95%) of the *allowed charge*, except when provided for outpatient *mental illness*, preventive care, smoking cessation, or the treatment of TMJ/MPDS.	Covered services of *network providers* are paid in full (after any applicable co-payment) except when provided for the treatment of *substance abuse, mental illness*, or TMJ/MPDS.
3. Non-network providers		
a. *Physicians, hospitals* and other covered health care *providers* in a license category eligible to participate in the *network*		
1) In service area	Covered services of non-network providers are paid at sixty percent (60%) of *usual and customary* charges in a location where there are *network providers* qualified to provide *medically necessary* services.*	Covered services of non-network providers are paid at sixty percent (60%) of *usual and customary* charges.**
2) Out of area	Covered services of non-network providers are paid at ninety-five percent (95%) of *usual and customary* charges in a location where there is no *network provider* qualified to provide *medically necessary services.*+	Covered services of non-network providers are paid at sixty percent (60%) of *usual and customary* charges.**
3) Emergency room	Covered services are paid according to *network* provisions for medical emergencies.	Varies by plan.

KEY

* These payment levels do not apply to coverage of treatment for *substance abuse, mental illness*, TMJ/MPDS, or vision care.

** These payment levels do not apply to coverage of treatment for *substance abuse, mental illness*, or TMJ/MPDS.

\+ This payment level does not apply to preventive care, smoking cessation, vision care, or the treatment of *mental illness, substance abuse*, or TMJ/MPDS.

	Traditional Medical Plan	Coordinated Care Plans
Plan payment levels (cont.)		
b. Other covered health care *providers, services and supplies* furnished by *providers* not in a license category eligible to participate in the selected *network*	Covered services are paid at eighty percent (80%) of *usual and customary* charges.*	Covered services must be approved by the plan; payment levels vary depending on the situation.
4. Ambulance services	Covered ambulance services are paid at ninety-five percent (95%) of *usual and customary* charges.	Varies by plan.
5. Durable medical equipment		
a. In regions where a *network* is available, as determined by the service representative	Covered durable medical equipment is paid according to *network provider* and non-network provider levels, as described in Section 11.C.2 and Section 11.C.3.a.1).	Covered durable medical equipment is paid at eighty (80%) percent of usual and customary charges; limits vary by plan.
b. In regions where a *network* is not available, as determined by the service representative	Covered durable medical equipment is paid at eighty percent (80%) of *usual and customary* charges, as described in Section 11.C.3.b).	Covered durable medical equipment is paid at eighty percent (80%) of usual and customary charges; limits vary by plan.
6. Alternatives to hospitalization	Covered *services and supplies* provided by a *skilled nursing facility* or a *hospice agency* are paid at one hundred percent (100%) of *usual and customary* charges.	When approved by the plan, covered *services and supplies* provided by a *skilled nursing facility*, a *home health care agency*, and a *hospice agency* are paid in full.
7. Treatment of *mental illness*		
a. Inpatient treatment coordinated through the *network's referral service*	Covered services for inpatient treatment of *mental illness* are paid at ninety-five percent (95%) of *allowed charges.*	Covered services for inpatient treatment of *mental illness* are paid in full to thirty (30) days each year if coordinated through the plan.
b. Outpatient treatment coordinated through the *network's referral service*	Covered services for outpatient treatment of *mental illness* are paid at a constant eighty percent (80%) of *allowed charges.*	Covered services for outpatient treatment of *mental illness* are paid in full to thirty (30) visits each year if coordinated through the plan.

	Traditional Medical Plan	Coordinated Care Plans
Treatment of mental illness (cont.)		
c. Treatment not *coordinated* through the *network's referral service*	Covered services for treatment of *mental illness* are paid at a constant fifty percent (50%) of *usual and customary* charges to a maximum of twenty (20) inpatient days and twenty (20) outpatient visits each year if the services are certified as covered by the *network's referral service.*	Covered services for treatment of *mental illness* are paid at a constant fifty percent (50%) of *usual and customary* charges to the thirty (30)-day inpatient and thirty (30)-visit outpatient limits if not coordinated through the plan.
8. Treatment of *substance abuse*		
a. Treatment coordinated through the *network's referral service*	Covered services for inpatient and outpatient treatment of *substance abuse* are paid at ninety-five percent (95%) of *allowed charges.*	Covered services for inpatient and outpatient treatment of *substance abuse* are paid in full if services are coordinated through the plan.
b. Treatment not coordinated through the *network's referral service*	Covered services for inpatient and outpatient treatment of *substance abuse* are paid at a constant fifty percent (50%) of *usual and customary* charges.	Covered services for inpatient and outpatient treatment of *substance abuse* are paid at a constant fifty percent (50%) of *usual and customary* charges if services are not coordinated through the plan.
c. Benefit maximum	Benefits are paid to a lifetime maximum of two courses of *treatment.* Each course of treatment not coordinated through the *referral service* is subject to a $5,000 maximum.	Benefits are paid to a lifetime maximum of two courses of *treatment* or $10,000, if greater. Each course of treatment not coordinated through the plan is subject to a $5,000 maximum.
9. *Neurodevelopmental therapy*	Covered services for *neurodevelopmental therapy* for children age six or younger are paid at *network* and non-network levels to a maximum of $1,000 each year.	Varies by plan.
10. Treatment of TMJ and MPDS	Covered services for treatment of TMJ and MPDS are paid at a constant fifty percent (50%) of *usual and customary* charges to a $3,500 lifetime maximum.	Varies by plan.
11. Smoking cessation treatment	Covered *services and supplies* are paid at one hundred percent (100%) of *usual and customary* charges to a $500 lifetime maximum.	Varies by plan.

	Traditional Medical Plan	Coordinated Care Plans
12. Preventive care		
a. *Network providers*	Covered services are paid in full; covered routine physical examinations for employees and spouses are paid up to $200 per examination, including related laboratory and X-ray charges.	Varies by plan.
b. Non-network providers	No coverage for services obtained in a *network* service area.	Varies by plan.
13. Vision care	Covered services are paid as specified in Section 11.F.	Varies by plan.
14. Prescription drugs		
a. *Network*		
1) Generic	Covered generic prescriptions or refills are paid at ninety percent (90%) of *allowed charges*, up to a thirty-four (34)-day supply.	Covered generic prescriptions or refills obtained from a *network* pharmacy are paid in full after required co-payments, up to a thirty (30)-day supply (supply varies by plan).
2) Brand-name *formulary*	Covered brand-name *formulary* prescriptions or refills are paid at eighty percent (80%) of *allowed charges*, up to a thirty-four (34)-day supply.	Covered brand-name *formulary* prescriptions or refills obtained from a *network* pharmacy are paid in full after required co-payments, up to a thirty (30)-day supply (supply varies by plan).
3) Brand-name non-formulary	Covered brand-name non-formulary prescriptions or refills are paid at seventy percent (70%) of *allowed charges*, up to a thirty-four (34)-day supply.	Covered brand-name non-formulary prescriptions or refills obtained from a *network* pharmacy are paid in full after required co-payments, up to a thirty-four (34)-day supply (supply varies by plan).
b. Non-network	Covered non-network prescriptions or refills are subject to the same payment levels described above for *network* drugs.	Not covered except when approved for emergency care.
c. Mail service prescription drug program		A *mail service prescription drug program* may not be available in all coordinated care plans.
1) Generic	Covered generic prescriptions or refills obtained from the *network's mail service prescription drug program* are paid in full after required co-payments, up to a ninety (90)-day supply.	Covered generic prescriptions or refills obtained from the *network's mail service prescription drug program* are paid in full after required co-payments, up to a ninety (90)-day supply.

	Traditional Medical Plan	Coordinated Care Plans
***Mail service prescription drug program* (cont.)**		
2) Brand-name *formulary*	Covered brand-name *formulary prescriptions or refills obtained* from the *network's mail service prescription drug program* are paid in full after required co-payments, up to a ninety (90)-day supply.	Covered brand-name *formulary prescriptions or refills obtained* from the *network's mail service prescription drug program* are paid in full after required co-payments, up to a ninety (90)-day supply.
3) Brand-name non-formulary	Covered brand-name non-formulary prescriptions or refills obtained from the *network's mail service prescription drug program* are paid in full after required co-payments, up to a ninety (90)-day supply.	Covered brand-name non-formulary prescriptions or refills obtained from the *network's mail service prescription drug program* are paid in full after required co-payments, up to a ninety (90)-day supply.
15. Out-of-pocket expense limits		
a. *Network*	*Network* services are subject to the same limits described below for non-network services.	Not applicable.
b. Non-network	When a covered person's out-of-pocket expenses reach $2,000 in any year, any further benefits that would have been paid at 60%, 70%, 80%, 90%, or 95% will be paid at 100% of *usual and customary* charges for the remainder of that year, to the maximum benefit amounts.	When a covered person's out-of-pocket expenses reach $2,000 in any year, any further benefits that would have been paid at sixty percent (60%) will be paid at one hundred percent (100%) of *usual and customary* charges for the remainder of that year, to the maximum benefit amounts.
	When two or more family members satisfy their deductibles and have combined out-of-pocket expenses of $4,000 (but not more than $2,000 for any one individual), any further benefits that would have been paid at *60%, 70%, 80%, 90%, or 95%* will be paid at 100% of *usual and customary* charges for the remainder of that year, to the maximum benefit amounts.	When two or more family members satisfy their deductibles and have combined out-of-pocket expenses of $4,000 (but not more than $2,000 for any one individual), any further benefits that would have been *paid at sixty percent (60%) will* be paid at one hundred percent (100%) of *usual and customary* charges for the remainder of that year, to the maximum benefit amounts.
c. Expenses that do not count toward the individual or family out-of-pocket expense limits	1) Yearly deductibles. 2) *Hospital* emergency room co-payment. 3) Office visit co-payment. 4) Difference between *usual and customary* charges and the *provider's* actual charge.	Varies by plan.

	Traditional Medical Plan	Coordinated Care Plans
Expenses that do not count toward the individual or family out-of-pocket expense limits (cont.)	5) Any balance remaining after a benefit maximum has been reached. 6) Covered medical services paid at one hundred percent (100%) of *usual and customary* charges or in full. 7) Covered medical services for treatment of *mental illness*, smoking cessation, *substance abuse*, or TMJ/MPDS. 8) Benefits paid at a reduced amount or denied when the patient fails to follow medical review program procedures and requirements.	

D. Lifetime Maximum Benefit

The lifetime maximum benefit for all covered medical services (including prescription drugs) is *$1,500,000, subject to all other medical plan provisions. This maximum applies separately to each* covered family member. Benefits paid and applied to reduce the maximum benefit, while covered under a *Company-sponsored plan* for active or retired personnel and not reinstated under a prior agreement, are not reinstated by this agreement and serve to reduce the maximum benefits available hereunder.

SECTION 11
TRADITIONAL MEDICAL PLAN

Payment provisions are described in Section 10, except as noted under the vision care benefit.

A. Description

The Traditional Medical Plan provides benefits for procedures, services, and supplies *medically necessary* for the diagnosis and/or therapeutic treatment of non-occupational accidental injuries or illnesses and treatment of certain listed conditions.

Enhanced benefits are available to employees who receive care from *network providers* as described in Section 10. Preventive care, prescription drug, and vision care benefits also are included in the Plan.

B. Medical Review Program

The Traditional Medical Plan has a medical review program to encourage appropriate utilization of health care services. The program includes *precertification* requirements, voluntary second surgical opinion provisions, a *referral service* for *mental illness* and *substance abuse* treatment, and individual case management.

1. *Precertification* requirements.

   The employee is responsible for obtaining *precertification* for all non-emergency *hospital* admissions (except admissions for childbirth during the first forty-eight (48) hours following a normal delivery or ninety-six (96) hours following a cesarean section), *skilled nursing facility* admissions, and services for home health care and hospice care. Treatment of *substance abuse* and *mental illness* must be precertified through the *referral service.*

a. If the medical review program is not contacted, but retrospective review shows that the *hospital* or *skilled nursing facility* admission, home health care, or hospice care was medically necessary, regular Plan benefits are reduced to fifty (50%) percent of *usual and customary* charges to a maximum employee expense of $1,000.

1) This $1,000 expense does not apply toward the yearly deductible and/or out-of-pocket expense limits.

2) Benefits denied under other Plan exclusions do not count toward this $1,000 expense.

b. No benefits are provided for any services or supplies that are not *medically necessary.*

2. Voluntary second surgical opinion provisions.

The Plan provides benefits for second surgical opinions the same as for other covered services provided by *network* and non-network providers.

3. *Referral service.*

Employees and eligible dependents may use a *referral service* for treatment of *mental illness* and *substance abuse.* The *referral service* refers the patient to a *referral service provider* and precertifies initial treatment; ongoing treatment is precertified on a regular basis. Individuals who do not use the *referral service* receive reduced benefits.

4. Individual case management.

In the event of a severe or long-term illness or injury, the *service representative* will assist the patient's *network provider* in identifying treatment alternatives that offer cost-effective care and enhancements to the patient's quality of life.

C. Preventive Care

1. Benefits are provided for a routine physical examination for employees and spouses as follows:

a. One (1) examination every three (3) years for employees and spouses under age 35.

b. One (1) examination every year for employees and spouses age 35 and above.

2. Benefits are provided for the following routine screening examinations:

Mammograms, Pap smears, and prostate examinations (including the office visit) as recommended by the patient's *physician.*

3. The Plan covers up to eight (8) routine physical examinations for well-baby care during the child's first twenty-four (24) months.

4. For children age two through age five, the Plan covers one (1) routine well-child physical examination each year.

5. The Plan covers routine childhood immunizations recommended by the child's *physician* according to American Academy of Pediatrics guidelines.

D. Covered *Medical Services and Supplies*

The Traditional Medical Plan provides benefits for the following procedures, services, and supplies medically necessary for the diagnosis and/or therapeutic treatment of non-occupational accidental

injuries or illnesses and treatment of certain listed conditions. Benefits for special conditions are specified in Section 11.E.

1. The services of a *physician*, including:

   a. A voluntary second (or third) surgical opinion obtained from one (1) or two (2) other specialists.

   b. An eye examination including refraction performed in conjunction with a medical condition such as diabetes, glaucoma, and cataracts. (See Section 11.F for routine eye examination coverage.)

   c. Injectable *legend drugs* administered in a *physician's* office for covered conditions; medical devices (including contraceptive injections, devices, and implants) dispensed by a *physician*. Preventive injections or immunizations are not covered except as described in Section 11.C. Antigen, allergy serum, and insulin are not considered a *physician's* service; antigen, allergy serum, and insulin are covered under the preferred pharmacy card program; insulin also is covered under the *mail service prescription drug program*.

2. Services of other health care professionals.

   a. Diagnostic X-ray and laboratory examinations, including examinations incurred in connection with a second (or third) surgical opinion.

   b. Intermittent visits of a registered nurse (R.N.), other than a nurse who ordinarily lives in the employee's home or who is a family member of the employee or spouse, if skilled care in place of hospitalization is not available through an alternative *provider* at a lesser cost.

   c. The services of a *physician's assistant* for services that would have been covered if performed by a *physician* licensed as a doctor of medicine (M.D.).

   d. The services of a *physical therapist* for physical therapy (but not other types of therapy), the services of an *occupational therapist* for occupational therapy, and the services of a *speech therapist* for speech therapy, when specifically prescribed by a *physician* as to type and duration. Services must be performed under the *physician's* supervision while the patient remains under the attending *physician's* care, and only to the extent that the therapy will significantly restore bodily functions. The *physician* must reevaluate the therapy at least every three (3) months and certify that continuing therapy is required. All therapy beyond three (3) months must be approved by the *service representative*. Benefit determination is based on the attending *physician's* evaluation of the therapy as well as the therapist's progress reports. The information from the *physician* and therapist is then reviewed against established medical criteria to determine medical necessity.

      No benefits are payable for therapy given at the therapist's discretion or elected by the covered person; any treatment for delayed development; therapy that is solely for the purpose of slowing body degeneration rather than restoring functional improvement; or therapy for custodial maintenance, self-help, recreational, or educational purposes.

      Benefits also are provided for *neurodevelopmental therapy* received from a licensed and certified therapist for children age six (6) and younger, including in-home therapy if homebound, to a maximum benefit of $1,000 each benefit year.

   e. The services of a *dentist* as specified in Section 11.E.6 and Section 11.E.10.

   f. The services of an authorized Christian Science practitioner necessary for the healing treatment of a non-occupational physical or mental condition.

g. Acupuncture services for a covered illness or in place of covered anesthesia when provided by a licensed acupuncturist (L.A.C.), a doctor of medicine (M.D.), or a doctor of osteopathy (D.O.).

h. Spinal and extremity manipulations by an approved *provider*, such as a doctor of medicine (M.D.), a doctor of osteopathy (D.O.), or a chiropractic doctor (D.C.), for up to twenty-six (26) spinal and extremity manipulations performed by hand each year. Related services, such as an initial examination and initial X-rays, also are covered.

3. Medical equipment, services, and supplies.

a. Professional ambulance service when used to transport the patient from the place of injury, accident, or illness to the first *hospital* where treatment is given. These services also are covered when the *physician* requires an ambulance to transport the patient to a *hospital* in the patient's area of residence to protect the patient's health or life. Air ambulance transportation is covered when *medically necessary*. Ambulance service from one *hospital* to another, including return, is covered only if the facility is the nearest one with appropriate regional specialized treatment facilities, equipment, or staff *physicians*. Ambulance transportation from or to the patient's home is covered when *medically necessary*. No other expenses in connection with travel are covered.

b. The cost and installation of a hearing aid or aids purchased under a *physician's* or certified audiologist's written recommendation, to a $600 benefit payable for each hearing aid. This benefit is limited to one (1) per ear every three (3) consecutive years, including any period covered under a *Company-sponsored plan*. The Plan also covers the overhaul of a hearing aid in place of a new hearing aid after three (3) years.

No benefits are payable for:

1) Hearing or audiometric examinations. (When disease is present, such expenses may be covered under other portions of the Traditional Medical Plan.)

2) Hearing aids ordered either before the person became eligible or after coverage ends.

3) Hearing aids ordered before coverage ends but delivered more than sixty (60) days after coverage ends.

4) Charges for hearing aids that do not meet professionally accepted standards of practice or for *experimental or investigational services or supplies*.

5) Replacement of hearing aids that are lost, broken, or stolen unless replacement is within the frequency limit of one (1) hearing aid per ear every three (3) consecutive years.

6) Replacement parts for hearing aid repairs, unless part of an overhaul after three (3) years.

7) Replacement batteries.

8) Charges for eyeglass-type hearing aids above the covered expense for one (1) hearing aid.

c. Hemodialysis in the patient's home when the treatment is repetitive and for chronic, irreversible kidney disease. Covered *services and supplies* include the rental, lease, or (under certain conditions) purchase of major hemodialysis equipment and specific supplies and certain training necessary to operate the dialyzer. Purchase of specific supplies is contingent on the supplies having no real utility to the patient in the absence of the disease and having no value to other household members. Coverage of the purchase of equipment is subject to specific conditions, including an amortization period, decided by the *service representative*.

d. Rental (or purchase if approved by the *service representative)* of durable medical or surgical equipment used exclusively for the patient's therapeutic treatment.

e. Orthopedic appliances and braces, including repair and replacement necessary as a result of normal usage or change in condition.

f. Oxygen and anesthesia.

g. Artificial limbs, artificial eyes, and other prostheses. This benefit includes repair and replacement necessary as a result of normal usage or change in condition.

h. Radiation therapy (including X-ray therapy) and chemotherapy.

i. Smoking cessation services, including the services of a *physician* or other health care professional who is practicing within the scope of his or her license, or an approved smoking cessation *provider.* To receive benefits for smoking cessation treatment, the patient must complete the full course of treatment. No smoking cessation benefits will be provided for inpatient services; vitamins, minerals, or other supplements; acupuncture; over-the-counter drugs or *provider*-prescribed prescription drugs to ease nicotine withdrawal; books; tapes; or hypnotherapy (unless performed by an approved *provider).* Prescription drugs prescribed by an approved *provider* to ease nicotine withdrawal are covered under the prescription drug benefit.

4. *Hospital* room, board, services, and supplies, including a *medically necessary* private room. If a private room is used when one is not *medically necessary,* any excess of daily board and room charges over the *hospital's* average semi-private room charge is not covered. If the *hospital* does not have semi-private accommodations, the semi-private charge for similar facilities in the area is considered in determining the rate.

   Hospital benefits are subject to the medical review program for medical necessity, appropriateness, level of care, and setting.

5. *Hospital* alternatives.

   a. Home health care visits and supplies provided to patients in their home by a *home health care agency* instead of confinement in a *hospital* or *skilled nursing facility.*

      Benefits are subject to the medical review program.

      1) To be eligible for benefits:

         a) Home health care visits and supplies must be for the *medically necessary* treatment of a covered illness or injury.

         b) A *physician* must establish a written *home health care treatment plan.*

         c) The patient must be homebound, which means leaving home involves a considerable, taxing effort and the patient is unable to use public transportation without assistance.

      2) Covered benefits for home health care visits and supplies must be provided by and billed by the *home health care agency* and are limited to:

         a) *Physician* services.

         b) Nursing visits by a registered nurse (R.N.) or licensed practical nurse (L.P.N.).

c) Physical therapy visits by a *physical therapist.*

d) Speech therapy visits by a *speech therapist.*

e) Occupational therapy visits by an *occupational therapist.*

f) *Medical social visits by a person with a master's degree in social work* (M.S.W.).

g) *Home health aide* visits.

h) Respiratory therapy visits by an inhalation therapist certified by the National Board of Respiratory Therapists.

i) Medical supplies dispensed by the *home health care agency* that would have been provided on an inpatient basis.

j) Nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation.

k) Nutritional guidance by a registered dietitian.

l) *Services and supplies* for infusion therapy. (Patients do not need to meet the treatment plan and homebound requirements.)

3) See Section 11.H. for listed home health care exclusions.

b. Visits and supplies of a *hospice agency* when provided in place of confinement in a *hospital* or *skilled nursing facility.*

Benefits are subject to the medical review program.

1) To be eligible for benefits:

a) Hospice care visits and supplies must be for the *medically necessary* treatment or palliative care of terminally ill patients with a life expectancy of six (6) months or less.

b) The *physician* must establish a written *hospice care treatment plan.*

2) Hospice visits and supplies in the patient's home must be provided by and billed by the *hospice agency* and are limited to the same items as listed under Section 11.D.5.a. In addition, benefits are provided for respite care for a minimum of two (2) hours per day (continuous patient care to provide temporary relief to family members or friends).

3) Expenses for inpatient hospice confinement are covered to the same extent as if incurred in a *hospital.*

4) Limits.

a) Respite care of two (2) or more hours per day when no skilled care is required is limited to a combined total of one hundred twenty (120) hours in each three (3)-month period.

b) Expenses for hospice care that qualify under this benefit and under any other benefit of this Plan are covered only under the benefit the *service representative* determines as the most appropriate.

Patients who exhaust the above limits may apply to the *service representative* for an extension of benefits, which will be approved by the *service representative* if the treatment is *medically necessary*.

5) See Section 11.H for listed hospice care exclusions.

c. *Skilled nursing facility* room, board, services, and supplies when provided in place of *medically necessary* hospitalization, limited to the facility's average semi-private room charge. If the *skilled nursing facility* does not have semi-private accommodations, the semi-private charge for similar facilities in the area is considered in determining the rate.

Benefits are subject to the medical review program for medical necessity, appropriateness, level of care, and setting.

Patients who exhaust the above limits may apply to the *service representative* for an extension of benefits, which will be approved if the treatment is *medically necessary*.

d. Expenses incurred for room and board while in a *Christian Science sanatorium* also are covered if the patient is admitted for healing (not rest or study) and is under the care of an authorized Christian Science practitioner. If a private room is used, any excess of daily room and board charges over the facility's average semiprivate room charge is not covered. If the facility does not have semiprivate accommodations, the semiprivate charge for other *Christian Science sanatoriums* will be considered in determining the rate.

e. Services of an approved free-standing surgical center or *hospital*-based emergency facility if such services would be covered if received in a *hospital*.

6. If the patient accepts a referral from the *service representative* to a *network provider* designated as a "center of excellence," reasonable travel and lodging expenses for the patient and the patient's family will be covered when the patient is required by the *service representative* to travel more than one hundred fifty (150) miles from his or her place of residence for an approved service. Benefits for travel expenses will be paid in full to a maximum of $2,500 per episode requiring travel and must be approved in advance by the *service representative*.

E. Special Conditions

Covered *medical services and supplies* described in Section 11.D also are provided for the following special conditions.

1. Congenital abnormalities and hereditary complications.

Benefits are provided for *medically necessary services and supplies* required for the treatment of congenital abnormalities and hereditary complications. This coverage applies to newborn children as well as to all other persons covered under the Plan.

2. Cosmetic surgery.

Benefits are provided for cosmetic surgery only if the surgery is for prompt repair of an accidental injury.

3. Erectile dysfunction.

Benefits are provided for the treatment of organic erectile dysfunction when the patient has a history of one or more of the following:

a. Peripheral vascular disease or local penile vascular abnormalities.

b. Peripheral neuropathy or autonomic insufficiency.

c. Prostate cancer. .

d. Spinal cord disease or injury.

e. Major pelvic surgery.

f. Insulin-dependent diabetes.

g. Severe Peyronie's disease.

Covered therapy includes vacuum erection device, injection therapy, penile prosthesis, urethral pellets, and prescription medications.

The Plan does not cover treatment for non-organic impotence such as psychosexual dysfunction.

4. Infertility.

Benefits are provided for the following services in connection with the diagnosis and treatment of infertility:

a. Diagnostic tests necessary to determine the cause of infertility.

b. Surgical correction of a condition causing or contributing to infertility.

c. Conventional medical treatments (such as office visits, laboratory services, and prescription medications) of the infertility.

The Plan does not cover the infertility *services and supplies* listed under "Traditional Medical Plan" Exclusions in Section 11.H.

5. *Mental illness* and *substance abuse* treatment.

a. *Mental illness.*

Benefits are provided for the services of the following *providers* in connection with the inpatient and outpatient treatment of *mental illness:*

1) Any *provider* contracted with the *referral service.*

2) Licensed psychiatric doctor (M.D.).

3) Licensed clinical psychologist.

4) Licensed psychiatric nurse (R.N.).

5) Professional at master's level or above whom is licensed in the area where the services are performed.

6) Licensed *hospital* or *treatment facility.*

Treatment of a *mental illness* includes only treatment of a mental disorder or condition not related to, accompanying, or resulting from *substance abuse.* Treatment of any such related, accompanying, or resulting disorder or condition is considered to be treatment of the *substance abuse.*

b. *Substance abuse.*

Expenses incurred at a *substance abuse treatment facility* or a *hospital,* including *physician's* charges and charges for prescription drugs, are covered only to the extent they are in connection with the effective treatment of *substance abuse.* The benefit at a *substance abuse treatment facility* is limited to intensive inpatient treatment and outpatient *substance abuse* counseling as prescribed by a *physician.*

No benefits are provided for recovery houses that provide an alcohol- or drug-free residential setting; alcohol or drug information and *referral services;* schools; emergency service patrols; or detoxification, except when immediately followed by a rehabilitative program.

The patient must complete the course of treatment to be eligible for *substance abuse* benefits.

6. Oral surgery.

a. Benefits are provided only to the extent not covered in the dental plans for services in connection with the prompt repair of natural teeth or other body tissue performed by a *physician* or *dentist* and required as a result of a non-occupational injury, provided that:

1) The damaged, lost, or moved teeth were free from decay or in good repair and firmly attached to the jaw bone at the time of the injury, and

2) If crowns (caps), dentures (false teeth), bridgework (fixed or removable), or in-mouth appliances are installed due to such injury, only charges for the first denture or bridgework to replace lost teeth, the first crown needed to repair each damaged tooth, and an in-mouth appliance used in the first course of orthodontic therapy after the injury are included.

Charges to remove, repair, replace, restore, or reposition teeth lost or damaged while biting or chewing are not covered.

b. Benefits are provided for *medically necessary services* in connection with oral surgery performed by a *physician* or *dentist* for a medical condition that does not relate to the correction of the gum, teeth, or mouth tissues for dental purposes, except where covered under the dental plans. These services include, but are not restricted to:

1) Removal of tumors and cysts of the jaw, cheeks, lips, tongue, and roof and floor of the mouth.

2) Surgical procedures required to correct accidental injuries of the jaw, cheeks, lips, tongue, and roof and floor of the mouth.

3) Removal of exostoses of the jaw and hard palate.

4) Treatment for fractures of the facial bones (maxilla or mandible).

5) Incision and drainage of cellulitis.

6) Incision of accessory sinuses, salivary glands, or ducts.

c. Benefits are provided for *physician* or *dentist* services in connection with the correction of developmental abnormalities of the jaw or malocclusion of the jaw by osteotomy (the surgical cutting of bone or bony tissue) with or without bone grafting.

d. The surgical placement of endosseous implants is covered if there is a reasonable expectation of success for a minimum of five (5) years.

e. *Hospital* services and benefits for general anesthesia are provided in connection with other dental or oral surgery when *medically necessary*.

The preceding listed services incurred in connection with dental work or oral surgery do not apply to any services in connection with the diagnosis and treatment of temporomandibular joint disease (TMJ) or myofascial pain dysfunction syndrome (MPDS). See Section 11.E.10.

7. Pregnancy.

Benefits are provided for pregnancy the same as any other condition for covered employees or covered dependents, provided that expenses are incurred while this coverage is in force.

Pregnancy includes normal delivery, cesarean section, spontaneous abortion (miscarriage), legal abortion, and complications of pregnancy.

Following childbirth, mothers and newborns may stay in the *hospital* for forty-eight (48) hours following a normal delivery or for ninety-six (96) hours following a cesarean section, unless a shorter stay is authorized by the attending health care *provider* in consultation with the mother. Preadmission review is not required for these lengths of stay. Any length of stay beyond forty-eight (48) hours or ninety-six (96) hours must be approved through the medical review program.

Benefits are provided for a *birthing center* only to the extent that such services would have been covered in a *hospital*.

A newborn child is eligible from the date of birth if the child qualifies as a dependent of the employee and is enrolled within one hundred twenty (120) days. The following services and supplies are covered for a newborn child enrolled in the Plan, subject to the payment provisions of Section 10.

a. Routine *hospital services and supplies* and *physician* services during the first forty-eight (48) hours following a normal delivery or ninety-six (96) hours following a cesarean section.

b. *Medically necessary hospital* and *physician services and supplies*.

8. Reconstructive breast surgery.

Benefits are provided for breast reconstruction in connection with the mastectomy in a manner determined in consultation with the patient and attending *physician*. Covered services include the following:

a. All stages of reconstruction of the breast on which the mastectomy was performed.

b. Surgery and reconstruction of the other breast to produce a symmetrical appearance.

c. Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedema.

9. *Sterilization (vasectomy and tubal ligation).*

Benefits are provided for a vasectomy or tubal ligation, but not a reversal.

10. Temporomandibular joint disease (TMJ) and myofascial pain dysfunction syndrome (MPDS).

a. The following surgical or nonsurgical treatment of TMJ or MPDS by a *physician* or a *dentist* are included as covered *medical services and supplies:*

1) Initial diagnostic examinations and X-rays.

2) Follow-up office visits.

3) Surgical procedures and related hospitalization.

4) Appliances (i.e., nightguards, bite plates, orthopedic repositioning, or mandibular orthopedic devices).

5) Appliance management, kinesitherapy, physical therapy, biofeedback therapy, joint manipulation, prescription drugs, injections of muscle relaxants, and therapeutic drugs or agents.

b. The following expenses are not covered:

1) Restorative techniques to build occlusion unless the tooth is diseased or accidentally damaged.

2) Non-surgical orthodontic treatment, except as provided above.

3) Banding treatment.

11. Transplant benefits.

Benefits are provided for *medically necessary services* relating to a covered transplant. Transplants that are part of an approved clinical trial also may be covered.

a. If the patient covered by this Plan is the recipient of a human organ or tissue transplant covered by this Plan, donor organ procurement costs are covered to a maximum benefit of $30,000 per transplant, to a lifetime maximum benefit of $60,000. Benefits are limited to selection, removal of the organ, storage, transportation of the surgical harvesting team and the organ, and other *medically necessary* procurement costs. Donor expenses that are covered under this Plan are applied against the Plan lifetime maximum benefit for the recipient covered under this Plan.

b. No benefits are provided for the following:

1) Nonhuman, artificial, or mechanical organ transplants.

2) *Experimental or investigational services or supplies* unless they are part of an approved clinical trial.

3) *Services and supplies* for the donor when donor benefits are available through other group coverage.

4) Expenses for that portion of treatment funded by government or private entities as part of an approved clinical trial.

5) Expenses when the recipient is not covered under this Plan.

6) Lodging, food, or transportation costs, unless otherwise specifically provided under this Plan.

7) Donor and procurement services and costs incurred outside the United States, unless specifically approved by the *service representative.*

8) Living (noncadaver) donor transplants (except kidney, liver, lobar lung, and bone-marrow or stem cell transplants for covered conditions) including selective islet cell transplants of the pancreas.

F. Vision Care Benefit

Vision care benefits are not subject to the Traditional Medical Plan annual deductible, out-of-pocket expense limits, plan payment levels, or lifetime maximum benefit.

1. Covered vision care expenses are charges (to the amounts shown in the Schedule of Covered Vision Care Expenses) for the following:

a. A complete eye examination of visual function, performed by a legally qualified ophthalmologist or optometrist.

b. Prescribed lenses.

c. Contact lenses if elected in place of conventional lenses and frames.

d. *Frames required for prescription lenses.*

Benefits are provided for one (1) eye examination every benefit year and two (2) sets of lenses and two (2) frames every two (2) benefit years (*network* and non-network combined). This period includes the time covered under a *Company-sponsored* medical plan. Any replacement of lost, stolen, or broken lenses and/or frames is included under the two (2)-set limit.

SCHEDULE OF COVERED VISION CARE EXPENSES

Services and Supplies	Maximum Covered Expense
Eye examination	Paid in full after $15 co-payment for *network provider* services Up to $50 for non-network provider services
Lenses	
• Single vision (2 lenses)	$50*
• Bifocal (2 lenses)	$80*
• Trifocal (2 lenses)	$95*
• Lenticular (2 lenses)	$155*
Frames	$70*
Contact lenses (2 lenses) in place of allowances for conventional lenses and frames above	$105*

* *Network providers* offer a discount on lenses, frames, and contact lenses; the employee will pay the *network provider* only the excess over the amounts shown in the schedule above. Non-network provider charges for lenses, frames, and contact lenses are reimbursed up to the amounts shown in the schedule above; no discount applies.

Patients will incur an additional charge for non-covered lens options such as lens coatings or hardening, tints, or photochromic, polycarbonate, or scratch-resistant or shatter-resistant lenses.

All other vision care expenses are not covered under this benefit, but may be covered as a medical condition under the Traditional Medical Plan.

2. The following vision care expenses are not covered:

   a. Special supplies, such as non-prescription sunglasses and subnormal vision aids.

   b. Orthoptics or vision training and any associated supplemental testing.

   c. Plano lenses (less than a ±.38 diopter power), two pair of glasses in lieu of bifocals, or extra charges for progressive lenses in excess of the bifocal allowance.

   d. Medical or surgical treatment of the eyes. (However, *network providers* offer discounts for refractive surgery.)

   e. Corrective vision treatment of an *experimental nature.*

   f. Solutions and/or cleaning products for spectacle glasses or contact lenses.

   g. Costs above the maximum covered expenses.

   h. Services or supplies not listed as covered expenses.

   i. Services or supplies received while the individual was not covered under the plan or charges for lenses and frames furnished or ordered before the individual became covered under the plan.

   j. Services or supplies received more than sixty (60) days after the *service representative* authorizes the patient's vision care benefits.

G. Prescription Drug Benefit

Benefits are subject to all Traditional Medical Plan provisions, including exclusions.

1. Preferred pharmacy card program.

   a. Description of benefit.

   Employees and dependents may obtain covered prescription drugs through the preferred pharmacy card program or through any licensed pharmacist.

   b. Covered prescription drug expenses.

   The Plan covers the following *medically necessary* prescription drug expenses:

   1) *Legend drug,* which must be dispensed under federal or state law through the written prescription of a *physician* or *dentist.*

   2) Injectable insulin (including needles, syringes, chem strips, chem pads and lancets when prescribed along with insulin) when ordered in writing by the patient's *physician.*

   3) Antigen or allergy serum prescribed by a *physician* in writing.

The Plan also covers prescribed *legend drugs* for contraception and smoking cessation.

However, any drug labeled "Caution – Limited by Federal Law to Investigational Use" or any experimental drug, even though a charge is made to the patient, is not a covered prescription expense.

c. Maximum medication covered.

The program covers a supply of medication which, when taken according to the *physician's* written order, does not exceed a thirty-four (34)-day supply.

2. *Mail service prescription drug program.*

a. Description of benefit.

Employees and eligible dependents may use the *mail service prescription drug program* to obtain covered prescription drugs.

Unless the *physician* indicates otherwise, a generic equivalent of the prescribed drug will be dispensed when available and permissible under the law.

b. Covered prescription drug expenses.

The Plan covers the following *medically necessary* prescription drug expenses:

1) *Legend drugs*, which must be dispensed under federal or state law through the written prescription of a *physician* or *dentist*.

2) Injectable insulin (including needles, syringes, chem strips, chem pads and lancets when prescribed along with insulin) when ordered in writing by the patient's *physician*.

The Plan also covers prescribed *legend drugs* for contraception and smoking cessation.

c. Maximum medication covered.

The program covers a supply of medication which, when taken according to the *physician's* written order, does not exceed a ninety (90)-day supply per prescription or refill. Authorized refills are covered only after the initial substance has been used. Certain controlled substances are subject to quantity limitations.

3. Exclusions.

No benefits are payable under the prescription drug programs for the following:

a. Appliances, devices, or other nondrug items, including but not limited to therapeutic devices or artificial appliances. However, this does not apply to needles, syringes, or other diabetic supplies when prescribed along with insulin.

b. Any charges for the administration or injection of any drug.

c. Any prescription for which the person is eligible to receive benefits under another employer's group benefit plan or a workers' compensation law or from any municipality, state, or federal program.

d. Any prescription filled in excess of the number prescribed by the *physician* or any refill after one (1) year from the date of the *physician's* order.

e. Immunizing agents, except that allergy serum (antigen) is covered under the prescription drug card program with a *physician's* written prescription.

f. All medications to treat sexual dysfunction, unless the patient is being treated for a diagnosed medical condition.

g. Fertility agents, unless approved by the *service representative.*

h. Obesity drugs.

i. Drugs dispensed during an inpatient admission by a *hospital, skilled nursing facility,* sanatorium, or other facility.

j. Experimental drugs or drugs used for investigational purposes.

k. Drugs that are not *medically necessary* for the treatment of an illness, injury, or other covered condition, including vitamins, except as specifically provided by the Plan.

l. Infusion therapy drugs except as described in the home health care benefit.

m. Delivery or handling charges.

n. Any service or supply otherwise excluded by the Plan.

H. Traditional Medical Plan Exclusions

These charges are deducted from the eligible person's expenses before the benefits of this Plan are determined. The Plan does not pay for charges for or related to:

1. Any accident or illness covered by a workers' compensation law.

2. Services or supplies not recommended and approved by a *physician* or other covered health care professional or provided before the person becomes covered under this Plan.

3. Services or supplies that the Plan's *service representative* determines are not *medically necessary* for treatment of an accidental injury, illness, or other condition covered under the Plan. This includes routine physical examinations, immunizations, or other preventive *services and supplies,* except as specifically provided by the Plan.

   Inpatient *hospital* care (including *physician* visits while hospitalized) is not considered *medically necessary* when the care can be provided safely in an outpatient setting, such as a *hospital* outpatient department, *physician's* office, or an ambulatory surgical facility, without adversely affecting the patient's physical condition.

   Examples of care that generally should be provided in an outpatient setting include observation and/or diagnostic studies, surgery that can be performed on a same-day basis, and psychiatric care primarily aimed at controlling or changing the patient's environment.

4. Amounts exceeding *usual and customary* charges.

5. *Skilled nursing facility* services when the services usually are not provided by such facilities or when the services are not expected to lessen the disability and enable the person to live outside the facility. However, *skilled nursing facility* services are covered for the terminal patient when the illness has reached a point of predictable end.

6. Services or supplies related to cosmetic surgery, except as specifically provided.

7. Services or supplies related to obesity, unless approved in advance by the *service representative* according to written guidelines. Employees may request a copy of the guidelines by calling the *service representative.*

8. Any treatment or services required in connection with a sex transformation.

9. Services or supplies to the extent they are covered under any *Company-sponsored plan* that has been discontinued.

10. Services or supplies to the extent they are covered under any federal, state, or other government plan, except where required by law.

11. Confinement or surgical, medical, or other treatment, services, or supplies received in or from a U.S. Government *hospital,* except as required by law.

12. Services or supplies for which no charge is made or charges the employee or dependent is not required to pay.

13. Dyslexia, visual analysis therapy, or training related to muscular imbalance of the eye, or for orthoptics. However, coverage is provided for up to six (6) months when necessary to correct muscle imbalance (strabismus, esotropia, or exotropia) if treatment begins before the person's 12th birthday.

14. Completion of claim forms or reports.

15. Full body computerized axial tomography (CAT) scans other than at a *hospital* or an institution having an agreement with a *hospital* to supply these services. However, expenses are covered under other circumstances if the equipment is required and certified by the *physician* for immediate use to diagnose a potentially life-threatening condition or if the services are provided at a *physician's* office, clinic, or other institution approved by the Company for other than emergency use.

16. Benefits payable under any automobile medical, personal injury protection (PIP), automobile no-fault, automobile uninsured or underinsured motorist, homeowner's, or commercial premises medical coverage when such contract or insurance is issued to or provides benefits available to the patient. Any benefits paid by this Plan before benefits are paid under one of these other types of contracts or insurance are provided to assist the patient and do not indicate the *service representative* is acting as a volunteer or waiving any right to reimbursement or subrogation.

17. *Experimental or investigational services or supplies,* or related complications.

18. Services or supplies related to treatment of *mental illness,* including eating disorders, or *substance abuse,* except as specifically provided.

19. Services or supplies related to treatment of TMJ and MPDS, except as specifically provided.

20. Smoking cessation treatment, except as specifically provided.

21. Radial keratotomy or other eye surgery to correct refractive errors, except when preoperative visual acuity is 20/50 or less with a lens.

22. Reversal of a sterilization procedure.

23. Infertility services or supplies, including but not limited to in vitro fertilization; artificial insemination; embryo transfer; gamete intrafallopian transfer (GIFT); microinjections; zona drilling; sperm preparation; sperm separation; fertility drugs (including but not limited to Clomid, Pergonal, Serophene, or HCG) when associated with any artificial means of conception; consecutive follicular ultrasounds, cycle therapy, or corresponding lab tests when associated with

any artificial means of conception; any tests, visits, consultations, or treatment related to, or resulting in, one of the preceding listed non-covered services.

24. *Custodial care.*

25. Services or supplies required by law to be provided by any school system.

26. Education, special education, or job training, whether or not provided by a facility that also provides medical or psychiatric care.

27. Marriage counseling, family counseling, child counseling, career counseling, social adjustment counseling, pastoral counseling, or financial counseling.

28. Intentionally self-inflicted injury, unless under treatment for a *mental illness.*

29. Missed appointments.

30. Equipment or supplies that are not solely related to the medical care of a diagnosed illness or injury. Examples include, but are not limited to, any luxury or convenience item or supply, general exercise equipment, modification to home (e.g., wheelchair ramps, support railings) or automobile or van (e.g., ramps, lifts), environmental control devices (e.g., air conditioners, purifiers, humidifiers), swimming pool, spa or whirlpool, Craftmatic or similar bed, orthopedic chair, special car seat, or any personal hygiene item.

31. The following home health care and hospice services:

    a. Homemaker or housekeeping services.

    b. Services provided by volunteers, household members, family, or friends.

    c. Unnecessary or inappropriate services, food, clothing, housing, or transportation.

    d. Social services.

    e. Psychiatric care.

    f. Maintenance or *custodial care.*

    g. Supplies or services not included in the written *home health or hospice care treatment plan* or not otherwise covered.

    h. Hospice services to other family members, including bereavement counseling.

    i. Hospice services of financial, legal, or spiritual counselors.

I. Right to Receive and Release Necessary Information

As a condition of receiving benefits under this Plan, the patient agrees to authorize:

1. Any *physician, hospital,* or other *provider* or party having knowledge to disclose to the service representative any medical information requested to administer this Plan.

2. The *service representative* to:

    a. Examine medical records at the offices of any *physician, hospital,* or other *provider* to verify services or supplies.

b. Release to or obtain from any other insurer, organization, or person any information necessary to administer the coordination of benefit provisions.

c. Exercise the subrogation rights described in Section 17 releasing any information about the accident, injuries, and benefits or services received to any person who may be liable to the patient, to that person's insurer, or to the *service representative*.

d. Examine employment and payroll records of the patient to verify Plan eligibility and enrollment.

3. The *service representative* will keep this information confidential whenever possible, but under certain circumstances it may be disclosed to other parties, such as:

a. To a law enforcement or other governmental authority in case of fraud or illegal activity.

b. In response to a subpoena or judicial order.

c. To a medical person or institution to verify coverage or to conduct an audit.

d. To a professional review organization to review the service or conduct of a medical person or institution.

4. The patient waives any claim of privilege or confidentiality in any action by or against the *service representative* or the party furnishing the information.

SECTION 12
DENTAL PLANS
(PREFERRED DENTAL PLAN AND PREPAID DENTAL PLAN)

A. Covered *Services and Supplies*

The following *services and supplies* are covered under both the Preferred Dental Plan and the Prepaid Dental Plan to the specified limits. The plans pay for covered services only if those services are performed by or under the direction of a licensed *dentist* or other plan-approved licensed professional. A licensed *dentist* does not mean a dental mechanic or any other type of dental technician. Coverage is subject to the benefit payment levels, exclusions, and other provisions of each dental plan.

1. Diagnostic.

Routine examinations, X-rays, emergency examinations, and examinations by specialists in an American Dental Association recognized specialty.

Examinations are covered once in a six (6)-month period. Charges to review a proposed treatment plan or for case presentation by the attending *dentist* are not covered. Complete mouth or panorex X-rays are covered once in a five (5)-year period. Supplementary bitewing X-rays are covered once in a twelve (12)-month period. Study and diagnostic models and decay susceptibility tests are not covered.

2. Preventive.

Prophylaxis (cleaning), either a regular prophylaxis or a periodontal prophylaxis, and topical application of fluoride.

Prophylaxis (cleaning), either a regular prophylaxis or a periodontal prophylaxis, is covered once in a four (4)-month period. Topical application of fluoride is covered once in a six (6)-month

period when performed in conjunction with prophylaxis, to the patient's 19th birthday. Home fluoride kits, cleaning of a *prosthetic appliance*, plaque control, oral hygiene, or dietary instructions are not covered.

Fissure sealants are covered for eligible children under age 14. Fissure sealants include topically applied acrylic, plastic, or composite material used to seal developmental grooves and pits in teeth for the purpose of preventing dental decay. Fissure sealants include application only to permanent molars with occlusal surfaces intact, no decay, and no restorations. Fissure sealants exclude any repair or replacement of a sealant on any tooth within three (3) years of its application. (This repair or replacement is considered included in the fee for the initial placement of the sealant.)

3. Restorative.

   a. Minor restorative.

      Restoration of carious lesions (visible destruction of hard tooth structure resulting from tooth decay) to a state of functional acceptability using filling materials, such as amalgam, silicate, or plastic.

   b. Major restorative.

      Restoration of carious lesions (visible destruction of hard tooth structure resulting from tooth decay) to a state of functional acceptability with crowns, inlays, or onlays (gold, synthetic porcelain, plastic, gold substitute castings, or combinations). The attending *dentist* must verify that teeth cannot be restored with filling materials such as amalgam, silicate, or plastic.

   c. Limits on minor and major restorative benefits.

      1) Restorations on the same surface or surfaces of the same tooth are covered once in a two (2)-year period. If a composite or plastic restoration is placed on a posterior tooth, an amalgam allowance is made.

      2) Crowns, inlays, or onlays on the same tooth are covered once in a five (5)-year period. Stainless steel crowns are covered once in a two (2)-year period. If a tooth can be restored with a filling material such as amalgam, silicate, or plastic, an allowance is made toward the cost of any other type of restoration.

      3) Appliances or restorations necessary to correct vertical dimension or restore the occlusion, overhang removal, recontouring, or polishing of restoration are not covered. A crown used as an abutment to a partial denture is not covered unless the tooth is decayed to the extent a crown would be required to restore the tooth whether or not a partial denture is required.

4. Oral surgery.

   Removal of teeth and surgical procedures. Covered services include surgical and non-surgical extractions, preparation of the alveolar ridge and soft tissues of the mouth for insertion of dentures, ridge extension for insertion of dentures (vestibuloplasty), and treatment of pathological conditions and traumatic facial injuries.

   Extraoral grafts (grafting of tissues from outside the mouth or using artificial materials) and tooth transplants are not covered.

5. Periodontics.

Surgical and non-surgical procedures for treatment of the tissues supporting the teeth. These include root planing, subgingival curettage, gingivectomy, and limited adjustments to occlusion (eight (8) teeth or fewer) such as smoothing of teeth or reducing cusps.

Periodontal splinting and/or crown and bridgework used in conjunction with periodontal splinting are not covered. Root planing or subgingival curettage (but not both) are covered once in a twelve (12)-month period. Major (complete) occlusal adjustment and periodontal appliances are not covered.

6. Endodontics.

Procedures for pulpal and root canal therapy. Covered services include pulp exposure treatment, pulpotomy, and apicoectomy.

Root canal treatment on the same tooth is covered only once in a two (2)-year period.

7. Pedodontics.

Space maintainers when used to maintain space for eruption of permanent teeth.

Replacement of a space maintainer previously paid for by the participating plan is not covered.

8. Prosthodontics.

Dentures, bridges, partial dentures, and related items and adjustment or repair of an existing prosthetic device.

Replacement of an existing prosthetic device is covered only if it is unserviceable and cannot be made serviceable. Services necessary to make the device serviceable are covered. Prosthetic devices are covered only five (5) years after any prior device was paid for under these plans.

a. Full, immediate, and overdentures.

If personalized restorations or specialized treatments are used, the Plan pays the appropriate amount for a full, immediate, or overdenture toward the cost of this treatment. Root canal therapy performed in conjunction with overdentures is limited to two (2) teeth per arch. Temporary dentures are not covered.

b. Partial dentures.

If a more elaborate or precision device is used to restore the case, the Plan pays for a cast chrome and acrylic partial denture (applied toward the cost of any other procedure).

c. Denture adjustments and relines.

Denture adjustments and relines done more than six (6) months after initial placement are covered. Subsequent relines or jump rebases (not both) are covered once in a twelve (12)-month period.

d. Implants.

The Plan pays the appropriate amount for a full or partial denture, applied toward appliances constructed on the implant. If the plan makes an allowance toward the cost of such appliances, it will not cover any replacement for five (5) years.

Duplicate dentures, cleaning of *prosthetic appliances*, temporary dentures, surgical placement or removal of implants or attachments to implants, or crowns and copings in conjunction with overdentures are not covered.

9. Orthodontics.

   Correction or prevention of malocclusion. Under the Preferred Dental Plan only, occlusal guards for bruxism are covered.

   Any services or supplies for orthodontic treatment (straightening of teeth) including correction or prevention of malocclusion, except as specifically provided as orthodontic care, are not covered.

10. General anesthesia.

    a. General anesthesia is covered when *medically necessary* and administered by a *dentist* in connection with a covered oral, endodontic, or periodontal surgical procedure.

    b. (Prepaid Dental Plan only) General anesthesia is covered when *medically necessary* for children through age six (6) and younger or for a physically or developmentally disabled person when administered in connection with a covered dental procedure.

B. Dental Plan Exclusions

The plans will not pay for charges for or related to:

1. Services payable under workers' compensation or employers' liability laws of any federal or state or provincial government agency or provided free to the eligible person by any similar agency, except to the extent that these payments are insufficient to pay for covered dental benefits.

2. Procedures, appliances, or restorations primarily for cosmetic purposes, including laminates or bleaching of teeth.

3. Any charge incurred while not covered under a *Company-sponsored plan;* however,

    a. Where the covered dental benefit was noted by the *dentist* as required before the employee terminated employment (unless the benefit was subject to the predetermination procedure and was submitted to the *service representative),* services are covered if performed during the three (3) calendar months after the termination.

    b. Charges in connection with a prosthetic device, which includes the abutment crowns of a partial denture, are covered if denture impressions were taken while the employee was actively employed and covered under these dental plans and were installed or delivered within the three (3) calendar months after termination of the employee's employment. Charges are not covered if denture impressions were taken before coverage began or after the date the employee terminated employment, unless they meet the requirements of subsection a. above.

    c. Charges in connection with a crown required to restore a tooth (independent of the use of the crown in connection with a partial denture) are covered if the tooth was prepared for the crown while the person was eligible or the crown was installed in accordance with subsection a. above.

    d. Charges in connection with covered orthodontic treatment are covered if performed during the three (3) calendar months after termination of the employee's employment.

4. Analgesics (such as nitrous oxide or intravenous sedation) or any other euphoric drugs, injections, or prescription drugs.

5. Hospitalization charges.

6. Full-mouth reconstruction (extensive treatment plans involving ten (10) or more crowns or units of fixed bridgework).

7. Failure to keep a scheduled dental appointment.

8. All other services not specified as covered dental benefits or not specifically included in this program.

9. Covered dental benefits for orthodontic care over the $2,000 lifetime maximum benefit for each *eligible person*.

10. Application of desensitizing medications.

11. Experimental dental services or supplies (and related complications) whose use is not generally recognized by the American Dental Association as tested and accepted dental practice. This exclusion also applies to items requiring Food and Drug Administration or other governmental agency approval if not granted when the service or supply was ordered.

12. Services to treat temporomandibular joints (jaw joints).

13. Patient management problems.

14. Completing insurance forms.

15. Laboratory examination of tissue specimen.

16. Habit-breaking appliances.

17. (Prepaid Dental Plan only) Services or treatment, which in the opinion of the *participating provider* are not necessary for the patient's dental health.

18. (Prepaid Dental Plan only) Removable partial bridges are covered only if replacing two (2) or more missing teeth in the same arch. Fixed bridges to replace missing teeth are considered optional treatment; the patient is responsible for the difference in cost between the *dentist's* allowable fees for the covered removable bridge benefit and the fixed bridge. Replacement of an exact existing fixed bridge is covered only if the existing bridge is at least five (5) years old and cannot be made serviceable.

SECTION 13
PREFERRED DENTAL PLAN

A. Description of Preferred Dental Plan

Under the Preferred Dental Plan, employees and eligible dependents may receive dental care from any licensed *dentist*. However, benefits are paid at a higher level if the services are received from a *network provider*. *Network providers* have agreed to bill the Plan's *service representative* directly, eliminating the need for claim forms.

B. Plan Payment Levels

The Plan pays for covered *services and supplies* as follows:

1. *Services and supplies* received from *network providers*.

a. Diagnostic and preventive *services and supplies* are paid at ninety (90%) percent of charges.

b. Oral surgery, minor restorative, periodontic, endodontic, and pedodontic services and supplies are paid at eighty (80%) percent of charges.

c. Major restorative, prosthodontic, and orthodontic *services and supplies* are paid at sixty (60%) percent of charges.

2. *Services and supplies* received from other covered *dentists* who are not *network providers.*

a. Diagnostic and preventive *services and supplies* are paid at seventy (70%) percent of *maximum allowable fees.*

b. Oral surgery, minor restorative, periodontic, endodontic, and pedodontic services and supplies are paid at seventy (70%) percent of *maximum allowable fees.*

c. Major restorative and prosthodontic *services and supplies* are paid at fifty (50%) percent of *maximum allowable fees.*

d. Orthodontic *services and supplies* are paid at sixty (60%) percent of *maximum allowable fees.*

C. Maximum Benefits

Except for orthodontic treatment, the maximum benefit payable for all dental services is $2,000 for each eligible person each year.

For orthodontic treatment, the lifetime maximum benefit payable during all periods the eligible person is covered under this Plan is $2,000.

SECTION 14
PREPAID DENTAL PLAN

A. Description of Prepaid Dental Plan

The Prepaid Dental Plan offers complete dental care to employees and eligible dependents by a *network* of *participating providers.*

B. *Provider* Selection

Employees must select a *participating provider* at enrollment. All covered dental services, except orthodontic and out-of-area emergency care, are provided to the employee and eligible dependents by this selected *provider.*

Employees wishing to transfer to another *participating provider* must contact the *service representative.* An approved transfer is effective the first day of the month following receipt of the change request by the *service representative,* if received by the 25th of the month.

Orthodontic care may be obtained from any licensed *dentist.*

C. Plan Payment Levels and Maximum Benefits

The Plan provides all necessary covered dental *services and supplies* at no cost to employees and eligible dependents except as specified below, subject to the plan's exclusions and limitations.

1. The Plan pays fifty (50%) percent of *maximum allowable fees* for orthodontic services to a $2,000 lifetime maximum during all periods the eligible person is covered under the Plan.

2. The Plan pays up to $50 of reasonable charges for out-of-area emergency *services and supplies.*

D. Out-of-Area Emergencies

The Plan provides an out-of-area emergency benefit for dental *services and supplies* provided by a licensed *dentist* who is not a member of the prepaid *provider network.* Out-of-area means the covered person is more than fifty (50) miles from the selected *participating provider.* The Plan pays reasonable charges for these *services and supplies,* without prior approval, to a maximum of $50. Payment for out-of-area emergencies is made only if all these conditions apply:

1. The dental care is provided by a *dentist* outside the Plan's service area.

2. The service or supply is covered under the Plan.

3. The dental care is required for an acute condition and is provided solely for the immediate relief of that condition.

4. The patient could not have been reasonably expected to go to the selected *participating provider* for the care.

SECTION 15
SCHEDULED DENTAL PLAN

A. Description of Scheduled Dental Plan

The Scheduled Dental Plan pays for covered expenses, to the maximum amounts listed in the Schedule of Covered Dental Services (Section 15.F.), in connection with the prevention, diagnosis, or treatment of dental disease or treatment of a non-occupational accidental injury.

B. *Provider* Selection

Employees and eligible dependents may receive dental care from any licensed *dentist.* They also may receive covered prosthodontic services from any licensed denturist.

C. Deductibles

Deductibles are expenses for certain covered *services and supplies* that the employee or dependent must pay each year before benefits are payable. Covered dental expenses are divided into two (2) categories for the purpose of applying deductibles:

1. Diagnostic and preventive services.

   Deductibles are not applied to covered dental expenses in this category.

2. All other covered dental expenses.

   The deductible for this category is $25 each year for each person covered under the Plan. However, if three (3) or more family members have a combined deductible totaling $75, no further deductible will be applied for any covered family member during the remainder of the year.

D. Plan Payment Levels

After satisfaction of the yearly deductible (and subject to the limitations and exclusions of the Plan), the Plan pays for covered *services and supplies* as follows:

1. The Plan pays the *maximum allowable fees* for the services listed below, but not more than the maximum expense indicated for each service in the Schedule of Covered Dental Services (Section 15.F.).

   a. Oral examinations, including scaling and cleaning of teeth.

   b. Topical application of sodium or stannous fluoride.

   c. Application of a fissure sealant.

   d. Dental X-rays.

   e. Extractions, including those required to correct malocclusion.

   f. Oral surgery, including excision of impacted teeth.

   g. Fillings.

   h. Treatment of periodontal and other diseases of the gums and mouth.

   i. Endodontic treatment, including root canal therapy.

   j. Space maintainers.

   k. Crowns and initial installation of fixed bridgework (including inlays and crowns to form abutments).

   l. Initial installation (including adjustments during the six (6)-month period following installation) of a prosthetic device (including crowns and inlays that form abutments).

   m. Replacement of an existing partial or full removable denture or fixed bridgework or the addition of teeth to an existing partial removable denture or to bridgework, but only if evidence satisfactory to the *service representative* is presented that:

      1) The existing denture or bridgework was installed at least five (5) years prior to its replacement and that the existing denture or bridgework cannot be made serviceable, or

      2) The existing denture or bridgework is an immediate temporary denture or bridgework and replacement by a permanent denture or bridgework is required, and takes place within twelve (12) months from the date of installation of the immediate temporary denture or bridgework.

   n. Repair or recementation of inlays, crowns, bridgework, dentures, or relining of dentures.

   o. Orthodontic care.

2. The allowance for a dental procedure not listed in the Schedule of Covered Dental Services is determined by taking into account the nature and complexity of the treatment. The allowance is consistent with those listed in the schedule. In no event will an allowance for an unlisted service be made for a procedure covered by the Medical Plan.

E. Maximum Benefits

Except for orthodontic treatment, the maximum benefit payable for all dental services is $2,000 for each eligible person each year.

For orthodontic treatment, the lifetime maximum benefit payable during all periods the eligible person is covered under this Plan is $2,000.

F. *Schedule of Covered Dental Services*

ADA Code		Maximum Covered Expense
	DIAGNOSTIC	
	Examinations (limit one per course of treatment):	
D0150	Comprehensive oral evaluation	$48
D0120	Periodic oral exam	26
D0140	Limited oral evaluation	37
	Radiographs (X-rays):	
	Complete mouth X-rays	
	(limit once in a five-year period)	
D0210	Intraoral (including bitewings)	69
D0330	Panoramic	53
	Intraoral periapical	
D0220	Single, first film	14
D0230	Each additional film	11
	Bitewings	
	(limit once in a 12-month period)	
D0270	Single film	13
D0272	Two films	21
D0274	Four films	32
	PREVENTIVE	
	Prophylaxis (limit once in a four-month period):	
D1110	Age 14 and over	58
D1120	To age 14	37
	Fluoride Treatment (limit once in a six-month period):	
D1203/D1204	Topical application of fluoride	21
	Fissure Sealants (to age 16):	
D1351	Topical application of fissure sealants (per quadrant)	26
	MINOR RESTORATIONS	
	Amalgam Restorations:	
D2140	Primary or permanent – one surface	58
D2150	Primary or permanent – two surfaces	74
D2160	Primary or permanent – three surfaces	95
D2161	Permanent – four surfaces	116
D2951	*Pin retention – exclusive of amalgam*	16
	Other Minor Restorations:	
D2330	Resin – one surface anterior	69
D2331	Resin – two surfaces anterior	90
D2332	Resin – three surfaces anterior	116
D2335	Resin – four or more surfaces anterior	127
D2391	Resin-based composite – one surface (primary or permanent)	74
D2392	Resin-based composite – two surfaces (primary or permanent)	100
D2393	Resin-based composite – three surfaces (primary or permanent)	127

ADA Code		Maximum Covered Expense
	MAJOR RESTORATIONS	
	Inlays and Onlays:	
D2510	Gold inlay – one surface	$217
D2520	Gold inlay – two surfaces	275
D2530	Gold inlay – three surfaces	317
D2542	Metallic onlay – two surfaces	379
D2543	Metallic onlay – three surfaces	412
D2544	Metallic onlay – four surfaces	412
D2910	Recement inlay	32
	Crowns:	
D2720	Resin w/high noble metal	380
D2721	Resin w/predominantly base metal	380
D2722	Resin w/noble metal	380
D2740	Porcelain/ceramic noble	380
D2750	Porcelain fused to high noble	380
D2751	Porcelain to predominantly base metal	380
D2752	Porcelain fused to noble	380
D2790	Full cast high noble metal	380
D2791	Full cast predominantly base metal	380
D2792	Full cast noble metal	380
D2782	Crown – **3/4** cast noble metal	380
D2930/D2931	Stainless steel	85
D2970	Temporary (fractured tooth)	63
D2950	Crown buildup	116
D2920	Recement crown	42
	ENDODONTICS	
D3110	Pulp cap – direct	32
D3120	Pulp cap – indirect	26
D3220	Vital pulpotomy	69
	Root Canal Therapy (includes treatment plan, clinical procedures, and follow-up care; excludes final restoration):	
D3310	Single rooted	312
D3320	Bi-rooted	412
D3330	Tri-rooted	512
D3410	Apicoectomy (performed as a separate surgical procedure)	412
	PERIODONTICS	
	Nonsurgical Services:	
D0180	Comprehensive periodontal evaluation	74
D4910	Periodontal prophylaxis (limit once in a four-month period)	79
D9951	Occlusal adjustment (limited)	106
D9952	Occlusal adjustment (complete)	306
D4341	Periodontal scaling and/or root planing (per quadrant)	95
	Surgical Services:	
D4210	Gingivectomy (per quadrant)	291
D4260	Osseous surgery (per quadrant)	644
D4271	Free soft tissue grafts	417
D7340	Vestibuloplasty	349

ADA Code		Maximum Covered Expense
	PROSTHODONTICS	
	Dentures (includes six (6) months post-delivery care):	
D5110/D5120	Complete upper or lower	$481
D5130/D5140	Immediate upper or lower	528
D5211/D5212	Partial upper or lower acrylic base (including any conventional clasps and rests)	317
D5213/D5214	Partial upper or lower, predominantly cast base with acrylic saddles (including any conventional clasps and rests)	581
	Related Denture Services:	
D5410-D5422	Denture adjustment (complete or partial)	34
D5510	Repair denture (no teeth damage)	48
D5520	Replace missing or broken tooth (per tooth)	48
D5710-D5721	*Denture conversion*	148
D5730-D5741	Reline denture – office	79
D5750-D5761	Reline denture – lab	148
	Bridgework:	
D6240-D6242	Pontic – porcelain – high noble, noble, and predominantly base	370
D6250-D6252	Pontic – resin – high noble, noble, and predominantly base	370
D6930	Recement bridge	63
	ORAL SURGERY	
	Extractions (includes local anesthesia and routine postoperative care):	
D7140	Extraction, erupted tooth or exposed root	63
D7210	Erupted tooth	127
D7220	Impacted tooth – soft tissue	143
D7230	Impacted tooth – partially bony	185
D7240	Impacted tooth – completely bony	227
D7250	Root recovery (per tooth)	132
	Related Oral Surgical Procedures:	
D7310	*Alveoloplasty – per quadrant*	*106*
D7510	Incision and drainage of abscess – intraoral	85
D7960	Frenectomy (separate procedure)	190
	General anesthesia (when not provided at a hospital):	
D9220	First 30 minutes	185
D9221	Each additional 15 minutes (or major fraction thereof)	63
	ORTHODONTICS *(coverage for employees and dependents)*	
	50 percent of *maximum allowable fees* to a lifetime maximum benefit of $2,000	

If two (2) or more dental services are rendered, payment will be made, subject to the provisions of the Scheduled Dental Plan, for each dental service unless the Schedule of Covered Dental Services specifies a maximum amount for a particular combination of the services rendered.

G. Limitations on Benefits

Covered dental services do not include and no benefits are payable for:

1. Charges for treatment by other than a *dentist.* However, this Plan will cover certain treatment by a licensed dental hygienist if the treatment is supervised by a *dentist.* The term *dentist* means a

legally qualified *dentist* practicing within the scope of such license. For the purposes of this Plan, the term *dentist* also includes a legally qualified *physician* authorized by license to perform the particular dental services that such person has rendered.

2. Charges for services or supplies that are partially or wholly cosmetic in nature, including charges for personalization or characterization of dentures.

3. Any charge incurred while not covered under this Plan. However, where the covered dental benefit was noted by the *dentist* as required before the employee terminated employment, services are covered if performed during the three (3) calendar months after the termination.

   a. In connection with the charges for a prosthetic device which includes the abutment crowns of a partial denture, such charges will be covered if the impressions were taken while the employee was employed and covered under this Plan and installed or delivered to the patient within the two (2) calendar months following termination of the employee's employment. Charges will not be covered if the impressions were taken before the date coverage commenced or if taken after the date of termination of the employee's employment.

   b. In connection with the charges for a crown required for the restoration of a tooth (independent of the use of the crown in connection with a partial denture), such charges will be covered if the tooth was prepared for the crown while the employee was employed and covered under this Plan and the crown is placed within the two (2) calendar months following termination of the employee's employment.

4. Charges for the replacement of a lost or stolen prosthetic device.

5. Charges for any services or supplies that are for orthodontic treatment (straightening of teeth), including correction or prevention of malocclusion, except as specifically provided.

6. Charges for treatment in connection with occupational accidents or illnesses covered by any workers' compensation law.

7. Charges for prophylaxis more often than once in each four (4)-month period.

8. Separate charges for anesthetics or the administration thereof, anesthetic supplies, or drugs, except general anesthesia when *medically necessary*.

9. That portion of a charge that exceeds *maximum allowable fees* or exceeds the maximum covered expense as shown in the Schedule of Covered Dental Services (Section 15.F).

10. Charges listed as exclusions in Section 15.H.

11. Charges for periodontal services or supplies, including periodontal splinting or bridgework, not specifically listed in the periodontics section of the Schedule of Covered Dental Services.

12. Charges for treatment of temporomandibular joint disease and myofascial pain dysfunction syndrome (TMJ/MPDS).

H. Scheduled Dental Plan Exclusions

No benefits are payable under this Plan for the charges listed below; the amount of any such charges will be deducted from the patient's expenses before the covered dental expenses are used to satisfy the deductible or before the benefits of this Plan are determined:

1. Charges that would not have been made if this Plan did not exist or charges that neither the employee nor any of the dependents of the employee is required to pay.

2. Charges for services or supplies that are furnished or paid for by reason of the past or present service of any person in the armed forces of a government.

3. Charges for services or supplies that are paid for or otherwise provided for under any law of a government, except where the payments or the benefits are provided by the government for its own civilian employees and their dependents, subject to the coordination of benefit provisions.

4. Charges for services or supplies that are not necessary for treatment of the injury or illness or are not recommended and approved by the attending *dentist* or charges that are unreasonable.

5. Charges for failure to keep a scheduled visit with the *dentist.*

6. Charges for completing claim forms.

SECTION 16
COORDINATION OF BENEFITS

If an employee or dependent has medical, dental, or other health coverage in addition to being covered under these medical and dental plans, the following rules govern coordination of benefits with the other coverage. Other coverage includes, whether insured or uninsured, another employer's group benefit plan, other arrangement of individuals in a group, Medicare (to the extent allowed by law), individual insurance or health coverage, and insurance that pays without consideration of fault.

The *service representative* has the right to obtain and release any information or recover any payment it considers necessary to administer these provisions.

The exclusion of government benefits and services is described in "Medical Plan Exclusions" in Section 11.H., in "Dental Plan Exclusions" in Section 12.B., and in "Scheduled Dental Plan Exclusions" in Section 15.H.

A. Order of Payment

The primary plan pays its benefits first and pays its benefits without regard to benefits that may be payable under other plans. When another plan is the primary plan for health care coverage, the secondary plan pays the difference between the benefits paid by the primary plan and what would have been paid had the secondary plan been primary.

1. A plan is considered primary if:

   a. It has no order of benefit determination rules.

   b. It has benefit determination rules that differ from coordination of benefit rules under state regulations or, if not insured, that differ from these rules.

   c. All plans that cover an individual use the same coordination of benefit rules, and under those rules, the plan is primary.

2. If the aforementioned rules do not determine which group plan is considered primary, this plan applies the following coordination of benefit rules:

   a. A plan that covers a person as an employee, retiree, member, or subscriber pays before a plan that covers the person as a dependent.

   b. A plan that covers a person as an active employee or dependent of an active employee is primary. The plan that covers a person as a retired, laid-off, or other inactive employee or as a dependent of a retired, laid-off, or other inactive employee is secondary.

c. If a dependent child is covered under both parents' group plans, the child's primary coverage is provided through the plan of the parent whose birthday comes first in the calendar year, with secondary coverage provided through the plan of the parent whose birthday comes later in the calendar year.

d. If a dependent child's parents are divorced or separated and a court decree establishes financial responsibility for the health care coverage of the child, the plan of the parent with such financial responsibility is the primary plan of coverage. If the divorce decree is silent on the issue of coverage, the following guidelines are used:

1) The plan of the parent with custody pays benefits first.

2) The plan of the spouse of the parent with custody pays second.

3) The plan of the parent without custody pays third.

4) The plan of the spouse of the parent without custody pays fourth.

e. If none of the aforementioned rules establishes which group plan should pay first, then the plan that has covered the person for the longest period is considered the primary plan of coverage.

f. Continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) always is secondary to other coverage, except as required by law.

g. If the employee or dependent is confined to a *hospital* when first becoming covered under this plan, this plan is secondary to any plan already covering the employee or dependent for the eligible expenses related to that *hospital* admission. If the employee or dependent does not have other coverage for *hospital* and related expenses, this plan is primary.

Benefits under a *Company-sponsored* medical or dental plan are not coordinated with benefits paid under any other group plan offered by the Company. An employee can receive benefits from only one (1) *Company-sponsored* medical or dental plan. However, when dental services performed by a licensed *dentist* also are covered under the medical plan, the dental plan pays its benefits first and the medical plan is secondary.

Federal rules govern coordination of benefits with Medicare. In most cases, Medicare is secondary to a plan that covers a person as an active employee or dependent of an active employee. Medicare is primary in most other circumstances.

B. Traditional Medical Plan

The primary plan pays benefits without regard to any other plan. When the Traditional Medical Plan is secondary, it adjusts benefits so that the total payable under both plans for expenses covered under the Traditional Medical Plan is not more than would be payable under the Traditional Medical Plan. Neither plan pays more than it would without coordination of benefits.

Plan means any plan providing medical, dental, vision care, hearing aid benefits, or treatment under individual insurance, group insurance, or any other coverage for individuals in a group, whether on an insured or uninsured basis.

Treatment of end-stage renal disease is covered by the Traditional Medical Plan for the first thirty (30) months following Medicare entitlement due to end-stage renal disease, and Medicare provides secondary coverage. After this thirty (30)-month period, Medicare provides primary coverage and the Traditional Medical Plan provides secondary coverage.

C. Coordinated Care Plans

Coordination of benefit provisions vary by plan.

D. Dental Plans

Benefits payable under the Scheduled Dental Plan, Preferred Dental Plan, and Prepaid Dental Plan take into account any coverage (including orthodontic coverage) the employee or family members have under another plan.

Plan means any plan providing medical, dental, vision care, hearing aid benefits, or treatment under group insurance or any other coverage for individuals in a group, whether on an insured or uninsured basis. However, plan excludes any medical plan sponsored by the Company. This means the dental plans pay first when dental expenses performed by a *dentist* also are covered by any medical plan sponsored by the Company.

The dental plans always pay regular benefits in full or a reduced amount that, when added to benefits payable by another plan, equals one hundred (100%) percent of allowable expenses.

Allowable expense means any charge, up to the *maximum allowable fees* incurred during a year and while eligible for benefits under the Scheduled Dental Plan, Preferred Dental Plan, or Prepaid Dental Plan part or all of which would be covered under any of the plans.

No benefits are payable under this provision unless the charges were incurred in connection with a dental service or treatment.

SECTION 17
WHEN AN INJURY OR ILLNESS IS CAUSED BY THE NEGLIGENCE OF ANOTHER

If a third party is legally liable for an injury or illness to a person covered under these medical and dental plans, regular plan benefits will be paid if the injured person agrees to cooperate with the *service representative* in administering the plan's subrogation rights. This includes providing all the necessary and requested information and submitting bills related to the injury or illness to any applicable insurer. The injured person also must agree to reimburse the plan if he or she recovers payment from the liable party or any other source. A third party includes any party possibly responsible for causing or compensating the injury or illness of a person covered under this plan, or the covered person's automobile, homeowner's, or other insurance coverage.

SECTION 18
DEFINITIONS

The following definitions apply to italicized terms in this document:

1. *Actively at work* means the employee is attending to his or her normal duties at the assigned place of employment. On a holiday, vacation day, weekend day, or other regularly scheduled day off, actively at work means the employee is not ill, injured, or otherwise disabled or confined to a *hospital* or similar institution, and is performing the normal activities of a person of his or her gender and age.

2. *Allowed charge* (Traditional Medical Plan, including preferred pharmacy card program) means the amount that would have been paid for like services or supplies to a *network provider* or *participating pharmacy* who has a participation agreement with the *service representative*.

3. *Birthing center* means a facility for normal delivery operating under the direction and control of the licensing or regulatory agency in its location.

4. *Chiropractor* means a person duly licensed in the area where his or her services are performed and practicing within the scope of that license.

5. *Christian Science sanatorium* means a facility that, at the time of the healing treatment, is operated (or listed) and certified by the First Church of Christ, Scientist, in Boston, Massachusetts.

6. *Company-sponsored plan* means a group health care or dental plan approved by Boeing or one of its subsidiaries or affiliates for its employees and dependents. This includes the Traditional Medical Plan, coordinated care plans, health maintenance organizations, Preferred Dental Plan, Prepaid Dental Plan, and Scheduled Dental Plan.

7. *Custodial care* means care that does not require the continuing services of skilled medical or health professionals and is primarily to assist patients in activities of daily living, including institutional care primarily to support self-care and provide room and board. *Custodial care* includes, but is not limited to, help in walking, getting into and out of bed, bathing, dressing, feeding and preparation of special diets, and supervision of medications that are ordinarily self-administered.

8. *Dentist* means a legally-qualified *dentist* practicing within the scope of his or her license.

9. *Experimental or investigational service or supply* means:

   a. A service or supply that meets at least one of the following criteria:

      1) It requires approval by the Food and Drug Administration or other government agency, which approval has not been granted when the service or supply is ordered.

      2) It has been classified by the national Blue Cross and Blue Shield Association as *experimental or investigational.*

      3) It is under clinical investigation by health professionals.

      4) It is not generally recognized by the medical profession as tested and accepted medical *practice.*

   b. However, a service or supply will not be considered experimental or investigational if it is part of an approved clinical trial. An approved clinical trial is one that meets each of the criteria in either Category 1 or 2 below.

      1) Category 1

         a) The trial has been approved by the National Institutes of Health, the Food and Drug Administration, the Department of Veterans Affairs, or a research center approved by the Plan's *service representative.*

         b) The trial has been reviewed and approved by a qualified institutional review board.

         c) The facility and personnel have sufficient experience and training to provide the treatment or use the supplies.

      2) Category 2

         a) The trial is to treat a condition that is too rare to qualify for approval under Category 1.

         b) The trial has been reviewed and approved by a qualified institutional review board.

c) The facility and personnel have sufficient experience and training to provide the treatment or use the supplies.

d) The available clinical or preclinical data provide reasonable expectation that the trial treatment will be at least as effective as non-investigational therapy.

e) There is no therapy clearly superior to the trial treatment.

10. *Experimental nature* (vision care benefit) means a procedure or lens that is not used universally or accepted by the vision care profession, as determined by the *service representative.*

11. *Formulary* means a list of drugs determined to be effective in both cost and treatment. A non-formulary drug also may be effective for treatment, but is not as cost-effective as *formulary* or generic drugs. A group of practicing *physicians* and pharmacists routinely reviews drugs to include in the *formulary.* If clinical data show several drugs are equally effective, the most cost-effective drug usually is chosen. The *formulary* may change from time to time.

12. *Home health aide* means an individual employed by a *home health care agency* or a *hospice agency* who provides, under the supervision of a registered nurse or *physical therapist* or *speech therapist,* part-time or intermittent personal care, ambulation and exercise, household services essential to health care at home, and assistance with medications ordinarily self-administered; reports on changes in patients' conditions; and completes appropriate records.

13. *Home health care agency* means a public or private organization that administers and provides home health care and is either Medicare certified or operating under the direction and control of the licensing or regulatory agency in its location.

14. *Home health* (or *hospice) care treatment plan* means a written program for continued care and treatment by the patient's attending *physician.* This plan must be reviewed and the continued need for care must be certified by a *physician* at least every two (2) months.

15. *Hospice agency* means a public or private organization that administers and provides hospice care and is either Medicare certified or operating under the direction and control of the licensing or regulatory agency in its location.

16. *Hospital* means an accredited institution licensed by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a general *hospital.*

17. *Legend drug* means any drug that is required by Federal law to be labeled "Caution: Federal law prohibits dispensing without a prescription."

18. *Mail service prescription drug program* means a mail service prescription company approved by the *service representative* to provide services under an arrangement with the *service representative.*

19. *Maximum allowable fee* (Dental Plans) means the maximum dollar amount that is allowed in reimbursement for any covered dental service, based on prevailing fees as determined by the *service representative.*

20. *Medically necessary procedure, service,* or *supply* means one that, in the reasonable opinion of the *service representative,* meets the following criteria:

a. It is required to diagnose or treat the patient's condition, and the condition could not have been diagnosed or treated without it.

b. It is consistent with the symptom or diagnosis and treatment of the condition.

c. It is the most appropriate service or supply essential to the patient's needs.

d. It is appropriate as good medical practice.

e. It is professionally and broadly accepted as the usual, customary, and effective means of diagnosing or treating the illness, injury, or condition.

f. When applied to an inpatient, it cannot safely be provided to the patient as an outpatient.

The fact that a procedure, service, or supply is furnished, prescribed, recommended, or approved by a *physician* does not, of itself, make it medically necessary. A service or supply may be medically necessary in part only.

21. *Mental illness* means a disorder (including an eating disorder) that exhibits symptomology, etiology, and features congruent with a *Diagnostic and Statistic Manual of Mental Disorders IV* diagnosis of mental disorder.

22. *Network* means a group of health care *providers* approved by the *service representative* as meeting criteria for efficient care delivery and performing services under a contract with the *service representative.*

The *service representative* may designate certain health care *providers* and facilities as *network providers* for specific medical services through a "centers of excellence" program.

23. *Network provider* means a *provider* who is a member of a *network.*

24. *Neurodevelopmental therapy* means physical, occupational, and speech therapy for treatment of neurodevelopmental delay. Neurodevelopmental delay means lack of development of motor or speech function not due to injury or trauma.

25. *Participating pharmacy* means a pharmacy that has an agreement with the *service representative* to accept payments in excess of the prescription drug coinsurance as payment in full for covered prescription costs.

26. *Participating provider* means a licensed *dentist* who has agreed to render services and receive payment according to the terms and conditions of a written *participating provider* agreement under the Prepaid Dental Plan.

27. *Patient safety standards* mean established criteria for patient safety related to *hospital* services. A *hospital* meets *patient safety standards* if it meets established criteria such as those listed below. The *hospital must publicly certify that it meets* all criteria and the statements pertaining to the standards are accurate and reflect normal operating procedures at the *hospital.* The criteria include:

a. Computerized *physician* order entry: the *hospital* requires *physicians* to enter all medication orders via computer linked to prescribing error-prevention software that helps eliminate confusion over paper prescription orders and alerts *providers* to negative drug interactions or other possible problems.

b. Intensive care unit staffing: the *hospital* that operates an adult general medical/surgical ICU assures all ICU patients are managed or co-managed by *physicians* certified (or eligible for certification) in critical care medicine during daytime hours, and intensivists are on call and available 24 hours a day.

c. Evidence-based *hospital* referrals: the *hospital* meets experience criteria for performance of specific, listed complex procedures.

28. *Physical therapist* or *occupational therapist* or *speech therapist* means a qualified *physical, occupational, or speech therapist* licensed in the jurisdiction where his or her services are rendered and practicing within the scope of that license. In locations without licensing requirements, the *physical therapist* must be certified by the American Physical Therapy Association, the *occupational therapist* must be certified by the American Occupational Therapy Association, and the *speech therapist* must be certified by the American Speech and Hearing Association.

29. *Physician* means only a *physician* who is licensed to prescribe and administer all drugs or to perform surgery. *Physician* also means the following health care professionals if they are licensed in the jurisdiction where they render services and are practicing within the scope of that license:

    a. Podiatrist.

    b. Psychologist.

    c. Optometrist.

    d. *Chiropractor.*

    e. Registered nurse (if services normally would have been performed by a Traditional Medical Plan *physician).*

    If a health care professional lawfully performs a service covered by the Traditional Medical Plan when performed by a *physician* and if applicable law requires recognition of this health care professional under the Traditional Medical Plan, the term *physician* will include the professional only to the extent required by law.

30. *Physician's assistant* means a person duly licensed in the area where his or her services are performed and practicing within the scope of such license.

31. *Plan administrator* means the Boeing Employee Benefit Plans Committee.

32. *Precertification* means prospective review and evaluation of proposed elective *hospital, substance abuse treatment facility,* and *skilled nursing facility* admissions as well as home health and hospice care by qualified health care professionals. This evaluation, which uses accepted medical criteria to determine medical necessity and whether treatment could be given in a less intense or more appropriate setting, may include:

    a. Patient safety review: referrals to *hospitals* which meet *patient safety standards,* including, for specific, listed complex procedures, *hospitals* that meet experience, volume, and outcomes criteria.

    b. Length of stay review: a process that begins during *precertification* review in which medical professionals indicate the number of inpatient days medically appropriate for the proposed admission or certify medical necessity of the intensity or type of services received for home health or hospice care. Follow-up reassessments and extensions are made as medically warranted.

    c. Concurrent review: ongoing review while the patient is undergoing treatment in the *hospital* or receiving care from a *home health care agency* or *hospice agency.*

    d. Discharge planning: discharge planning is designed to identify patients who could be discharged early if appropriate arrangements are made for covered alternative care.

    e. Retrospective review: Retrospective review includes all the steps of *precertification* review, but after services are rendered. Retrospective review occurs when the medical review

program (or *referral service* for the treatment of *substance abuse* and *mental illness*) is not contacted before treatment.

The role of the reviewing organization is to advise on medical appropriateness. The patient and *physician* decide on the treatment actually performed. Medical review affects payments under the Traditional Medical Plan as specified in Section 11.B.

33. *Prosthetic appliance* means a denture, partial denture, fixed or removable bridge, crown used as a bridge abutment, and other related items.

34. *Referral service* means an organization that manages treatment of *substance abuse* and *mental illness* by contracting with *providers* of this treatment. The organization is responsible for:

    a. Assessment of the patient's condition (including crisis intervention).

    b. Referrals to *referral service providers.*

    c. *Precertification* review of treatment for *substance abuse, mental illness,* and eating disorders.

    d. Initial and ongoing review of *provider* treatment plans to assure services are *medically necessary* and given in the appropriate setting.

    The *referral service* is considered the *service representative* for determining medical necessity of *substance abuse* and *mental illness.*

35. *Referral service provider* means a *provider* performing services under a contract with the *referral service* or a *provider* meeting *referral service* criteria for care to a designated patient.

36. *Service representative* means an agent who has a contract with the Company to make benefit determinations and administer benefit payments under the plans described in this document. The Company may change a *service representative* at any time.

37. *Skilled nursing facility* means an institution approved as such by Medicare.

38. *Substance abuse* means alcohol or drug dependence as classified in categories 303.0 to 304.9 of the most current edition of the *International Classification of Diseases, 9th Revision, Clinical Modification.*

39. *Substance abuse (alcoholism and/or drug abuse) treatment facility* means an institution providing treatment for chronic alcoholism and/or drug abuse and operating under the direction and control of the licensing or regulatory agency in its location.

40. *Usual and customary* (Traditional Medical Plan), as determined by the *service representative,* is the lowest of these amounts:

    a. The *provider's* actual charge to the patient after any discounts or other reductions.

    b. The charge most frequently made by the *provider* to all other patients for comparable services or supplies.

    c. The charge most frequently made by *providers* with similar professional qualifications for comparable services or supplies in the same geographic area.

    d. In the service area of a *network,* the amount that would have been paid for like services or supplies to a *provider* who has a participating agreement with the *service representative.*

The *usual and customary* charge for an unusual or complicated service will be evaluated by considering charges to treat illnesses or injuries of a comparable nature or complexity.

SECTION 19
TERMINATION OF COVERAGE

A. Life Insurance Coverage

Life insurance coverage stops on the date employment terminates.

Within thirty-one (31) days after the employee terminates employment, by making application and paying first premium to the Plan's insurer, the employee may convert life insurance coverage to an individual life insurance policy on any regular whole life insurance plan. This individual policy will be issued, without medical examination, at the insurer's regular rates. The amount of life insurance converted cannot exceed the amount in force on the date insurance terminates.

If, after an individual conversion policy is issued, benefits under the Life Insurance Plan are continued due to total disability, the individual policy must be surrendered without claim other than the return of paid premiums.

If the employee dies within the thirty-one (31)-day conversion period, the conversion amount is payable.

An employee who is being transferred and is no longer eligible for coverage under the Life Insurance Plan, but who remains employed by the Company or one of its subsidiaries, also may convert the difference between the amount of life insurance provided by the Life Insurance Plan less the amount provided by the plan for which the employee has become eligible. Application must be made within thirty-one (31) days of the date of transfer.

B. Accidental Death and Dismemberment Coverage

Accidental death and dismemberment coverage stops on the date employment terminates.

C. Medical Coverage

Medical coverage for the employee and dependents stops at the end of the calendar month in which the employee terminates employment or the end of the last month required contributions are paid, whichever occurs first. If earlier, a dependent's coverage stops at the end of the month in which he or she no longer qualifies as a dependent.

However, coverage may be continued under certain circumstances as specified below. Any required contributions must be paid during these periods for coverage to continue.

1. In case of layoff, medical coverage for employees and dependents continues until the employee is covered by any other group medical plan either as an employee or as a dependent, but in no event beyond three (3) months after the date of layoff.

2. If the employee dies (other than from an industrial accident), medical coverage continues for eligible dependents until the earlier of twelve (12) months after the employee's death or when the dependents become covered by any other group medical plan.

3. If the employee dies from an industrial accident, medical coverage continues for eligible dependents until the earlier of thirty-six (36) months after the employee's death or when the dependents become covered by any other group medical plan.

The *service representative* will make available to a terminating employee an individual program of medical benefits similar to those then being issued for group conversion. The benefits provided under the individual plan will not exactly duplicate the benefits provided under this group medical plan. This conversion privilege is also available to covered dependents that cease to qualify under the group policy and to surviving covered dependents if the employee dies. No evidence of insurability is required.

D. Dental Coverage

Dental coverage for the employee and dependents stops at the end of the calendar month in which the employee terminates employment. If earlier, a dependent's coverage stops at the end of the calendar month in which the dependent no longer qualifies as a dependent.

1. If the employee dies (other than from an industrial accident), dental coverage continues for eligible dependents until the earlier of twelve (12) months after the employee's death or when the dependents become covered by any other group dental plan.

2. If the employee dies from an industrial accident, dental coverage continues for eligible dependents until the earlier of thirty-six (36) months after the employee's death or when the dependents become covered by any other group dental plan.

E. Change in Eligible Class of Employment

When an employee remains employed by the Company but is no longer in the employee class eligible for coverage under this Package, coverage for the employee and dependents stops at the end of the month in which the employee's transfer is effective. If the employee becomes totally disabled before coverage ends under the Package, the life insurance and accidental death and dismemberment benefits of the Package, which would have continued if the employee had stayed in the eligible class, will continue during the total disability instead of all other Company life insurance and accidental death and dismemberment benefits.

F. Continuation of Medical and Dental Coverage (COBRA)

If medical and dental coverage for the employee and dependents (including a same-gender domestic partner and his or her children) otherwise would terminate due to one of the following reasons, these benefits may continue for specified periods under Public Law 99-272, Title X, as amended, if the individual makes a timely request to the Company and pays the required contribution:

1. Reduction in hours or termination of employment for any reason.

2. The employee's death.

3. The employee's divorce or dissolution of a same-gender domestic partner relationship.

4. A dependent child ceasing to be a dependent as defined under this Package. (A child eligible to be continued under the Package's incapacitated child provision still will be considered to have dependent status.)

5. A dependent's loss of eligibility because the employee became eligible for Medicare.

SECTION 20
LEAVES OF ABSENCE

When an employee is absent with leave, coverage may continue as follows; any required contributions must be paid during these periods for coverage to continue.

A. Approved Medical Leaves of Absence

An employee who is eligible for coverage and begins an approved medical leave of absence due to a total disability is eligible for the Package the same as an active employee until the last day of the calendar month in which the leave began. (Eligible dependents also are eligible for medical and dental benefits.)

If the employee is totally disabled and remains on an approved medical leave of absence that extends beyond this period, the employee's life insurance, accidental death and dismemberment, medical, and dental benefits (and dependent medical and dental benefits) continue up to six (6) full consecutive calendar months during the approved medical leave with Company contributions.

If the approved medical leave extends beyond this six (6)-month period due to continuous total disability, medical coverage for the employee continues for up to an additional twenty-four (24) months with Company contributions. (If an employee is not on an approved medical leave and has been totally disabled for six (6) consecutive months, this twenty-four (24)-month provision may apply.) Medical coverage ends earlier if the employee becomes eligible for Medicare or is no longer considered totally disabled. The employee also may continue the life insurance, accidental death and dismemberment, and dental benefits (and medical and dental benefits for eligible dependents) during this time by paying the required rates on or before the 10th day of the month in which they are due. Life insurance waiver of premium may apply if approved by the *service representative.*

If the total disability continues beyond the thirty (30)-month period, or a covered family member is considered disabled by Social Security during the seventh or eighth month of the absence, the employee may continue medical and dental coverage for himself/herself and eligible dependents for up to five (5) more months by paying one hundred fifty (150%) percent of the cost of coverage. The employee may continue life insurance and accidental death and dismemberment coverage for the duration of the approved leave of absence.

B. Other Approved Leaves of Absence

An employee who is eligible for coverage and begins an approved leave of absence is eligible for the Package the same as an active employee until the last day of the calendar month in which the leave began. (Eligible dependents also are eligible for medical and dental benefits.)

If the approved leave extends beyond this time, the employee's life insurance, accidental death and dismemberment, medical, and dental benefits (and dependent medical and dental benefits) continue for up to three (3) full consecutive calendar months with Company contributions.

If the approved leave extends beyond this time, the employee may continue life insurance coverage for the duration of the approved leave of absence by self-paying the premiums.

C. Family and Medical Leave Act of 1993

If the required coverage for family and medical leaves of absence under the Family and Medical Leave Act of 1993 is more generous than that already provided in Section 20.A. and Section 20.B., the Company provides any required additional coverage under its group health plans.

D. Uniformed Services Leave of Absence

If the employee takes a leave of absence for service in the U.S. uniformed services (including the military, National Guard, and the Commissioned Corps of the Public Health Service), he or she is covered under the Package until the end of the month in which the leave began. If the employee remains on an approved leave of absence, coverage under the Package continues until the end of the third full calendar month of the leave as if the individual were an active employee on an approved non-medical leave of absence.

If uniformed service extends beyond three (3) months, the employee may continue medical and dental coverage under COBRA.

If the employee returns to active employment promptly after uniformed service, according to federal law the Package is reinstated on the date the employee returns to the active payroll.

E. Changes in Leave Types

For an employee changing directly from an approved non-medical leave to an approved medical leave or from an approved medical leave to an approved non-medical leave, the coverage period provided with Company contributions under one type of leave reduces the coverage period provided with Company contributions under the other type of leave.

F. Successive Periods of Leaves of Absence

Two (2) medical leaves of absence separated by fewer than thirty (30) days of continuous work are considered one (1) leave of absence unless the second leave is due to entirely unrelated conditions.

ATTACHMENT B

SOCIETY of PROFESSIONAL ENGINEERING EMPLOYEES in AEROSPACE

(Wichita Technical and Professional Unit)

RETIREE MEDICAL PLAN

TABLE OF CONTENTS

SECTION 1
ELIGIBLE RETIRED EMPLOYEES

To be eligible for the Retiree Medical Plan, the employee must retire from the service of the Company under The Boeing Company Employee Retirement Plan at age 55 or older with ten (10) or more years of vesting service under a Company-sponsored retirement plan.

If an employee becomes eligible for disability benefits under The Boeing Company Employee Retirement Plan, the employee also is eligible for the Retiree Medical Plan if he or she is at least age fifty (50) and has ten (10) or more years of vesting service at retirement.

An employee who is at least age fifty-five (55) and has ten (10) or more years of vesting service at retirement is eligible for the Retiree Medical Plan if he or she retires under The Boeing Company Employee Retirement Plan within the following time limits:

- Two (2) years following the start of an approved pre-retirement leave of absence, provided the approved leave of absence has not ended prior to the employee's retirement.

- Six (6) years following the employee's layoff.

An employee who is eligible for the Retiree Medical Plan at the time active employment with the Company ends and who defers his or her retirement benefits also must defer enrollment in the Retiree Medical Plan until the date benefits begin under the Company-sponsored retirement plan.

A retired employee no longer is eligible for coverage under the Retiree Medical Plan described in this Attachment after attaining age 65 or becoming eligible for Medicare.

SECTION 2
ELIGIBLE DEPENDENTS OF RETIRED EMPLOYEES

Dependents eligible for the Retiree Medical Plan are the retired employee's legal spouse and unmarried children (natural children, adopted children, children legally placed with the retired employee for adoption, and stepchildren) who are under age 25 and dependent on the retired employee for principal support, including children who are attending school.

A retired employee may request coverage for the following dependents:

1. A common-law spouse if the relationship meets the common-law requirements for the state in which the retired employee entered into the common-law relationship. (A domestic partner is not considered an eligible spouse.)

2. Other children, as follows, who are under age 25, unmarried, and dependent on the retired employee for principal support, including children who are attending school:

    a. Children who are related to the retired employee either directly or through marriage (e.g., grandchildren, nieces, nephews).

    b. Children for whom the retired employee has legal custody or guardianship, or has a pending application for legal custody or guardianship, and are living with the retired employee.

Annual certification of eligibility is required to continue coverage for children from age 19 through age 24.

In accordance with federal law, the Company also provides medical coverage to certain dependent children (called alternate recipients) if the Company is directed to do so by a qualified medical child support order (QMCSO) issued by a court or state agency of competent jurisdiction.

Documentation is required to request coverage for a child named in a QMCSO or for a child for whom the retired employee has been given legal custody or guardianship.

A disabled child age 25 or older may continue to be eligible (or enrolled if the employee is a newly eligible employee) if he or she is incapable of self-support due to any mental or physical condition that began before age 25. The child must be unmarried and dependent on the employee for principal support. Coverage may continue under the Retiree Medical Plan for the duration of the incapacity as long as the employee continues to be eligible under the Plan and the child continues to meet these eligibility requirements.

Special applications for coverage are required for disabled dependent children age 25 or older.

A spouse or dependent child no longer is eligible for coverage under the Retiree Medical Plan described in this Attachment after attaining age 65 or becoming eligible for Medicare.

SECTION 3
HOW TO ENROLL

A. Initial Enrollment

The retired employee and eligible dependents automatically will be enrolled at the time the retired employee becomes eligible, provided the retired employee pays any required contributions. The retired employee and dependents are enrolled in the same plan as immediately before retirement, if applicable.

A retired employee who has been enrolled in a health maintenance organization (HMO) or coordinated care plan may elect to change to the Traditional Medical Plan by calling the Boeing Service Center within thirty-one (31) days of the date the employee retires. The Company will supply enrollment instructions at the time of retirement.

All family members, including the retired employee, must be enrolled in the same medical plan.

B. Spouse Coverage

Each retired employee with a spouse must provide information regarding coverage available through another employer to determine whether special contributions are required to enroll the spouse. If the retired employee does not authorize a required contribution, the spouse will not be enrolled for medical coverage. The retired employee will not be able to enroll the spouse until the date the spouse loses the option to be covered under the other employer-sponsored medical plan.

The Company will require periodic verification of data.

C. Special Enrollment

If a retired employee declined enrollment for himself/herself or dependents in the Retiree Medical Plan because of other employer-sponsored health care coverage (such as through a spouse's employer), the retired employee may be able to enroll himself/herself and eligible dependents in the Company-sponsored Retiree Medical Plan at a later date as long as enrollment is within sixty (60) days after other coverage ends.

If a retired employee declined enrollment for himself/herself or dependents when first eligible and the retired employee's or dependent's other health care coverage was through continuation coverage from a previous employer (coverage mandated by the Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA), the retired employee or dependent must exhaust his or her COBRA coverage to be eligible for the special enrollment period.

If a retired employee's or dependent's other health care coverage was not through COBRA, the coverage loss must be due to loss of eligibility for that health care coverage (including from divorce, death, termination of employment, or reduction in hours of employment) or termination of employer contributions toward such coverage.

If a retired employee is not enrolled in the Company-sponsored Retiree Medical Plan and has a new dependent as a result of an event such as marriage, birth, adoption, or placement for adoption, the retired employee may enroll himself or herself, his or her spouse, and any dependent children during the year as long as enrollment is requested within sixty (60) days after the event by contacting the Boeing Service Center.

If a retired employee is enrolled in the Retiree Medical Plan and has a new dependent as a result of marriage, birth, adoption, or placement for adoption, the retired employee may enroll the new dependent during the year as long as enrollment is requested within one hundred twenty (120) days after the qualified event. See "Change of Dependent Status," Section 3.E., for more information.

D. Transfer Between Plans

Transfer between plans is permitted only during authorized annual enrollment periods or following a change of residence.

1. Annual enrollment period.

   The Company establishes an annual enrollment period each year when retired employees may change medical plans.

2. Change of residence.

   A retired employee who moves out of an HMO or coordinated care plan service area has sixty (60) days to select a medical plan available in the new location by calling the Boeing Service Center.

   It is the retired employee's responsibility to notify the Company of the change in residence within the sixty (60)-day period.

E. Change of Dependent Status

A retired employee will not be able to make dependent enrollment changes until the next annual enrollment period unless the retired employee experiences one of the qualified changes in status described in this section. Any change in enrollment must be consistent with the change in status. To be consistent, the event must cause the retired employee or family member to gain or lose eligibility for the Company-sponsored health care coverage or health care coverage sponsored by a spouse's or dependent child's employer, and the election change must be on account of and correspond with the gain or loss of eligibility. Qualified changes in status include the following:

1. The retired employee marries, divorces, or becomes legally separated, or the marriage is annulled.

2. The retired employee acquires a new, eligible dependent child, such as by birth, adoption, or placement for adoption.

3. The retired employee's spouse or dependent child dies.

4. The retired employee, spouse, or dependent child starts or stops working.

5. The retired employee, spouse, or dependent child has any other change in employment status that affects eligibility for coverage such as changing from full time to part time (or part time to full

time), salaried to hourly (or hourly to salaried), strike or lockout, or beginning or returning from a leave of absence.

6. The retired employee, spouse, or dependent child experiences a significant increase in the cost of employer-sponsored health care coverage or the employer-sponsored health care coverage ends, including expiration of COBRA coverage.

7. The retired employee, spouse, or dependent child experiences a significant curtailment or cessation of employer-sponsored health care coverage.

8. The retired employee, spouse, or dependent child becomes eligible or ineligible for Medicare or Medicaid.

9. The retired employee's dependent child becomes eligible for, or no longer is eligible for, health care coverage due to age limits or a similar eligibility requirement.

10. The retired employee, spouse, or dependent child makes an enrollment change in his or her employer-sponsored health care coverage, either because of a qualified change in status or an annual enrollment.

11. The retired employee, spouse, or dependent child changes place of residence or work, affecting access to care within the current plan.

The retired employee also may change an election to comply with a qualified medical child support order (QMCSO) to provide or cancel coverage for a child resulting from a divorce, annulment, or change in legal custody.

In most situations, the retired employee must request the dependent enrollment change within sixty (60) days after the qualified event. A retired employee can enroll a new dependent within one hundred twenty (120) days following the retired employee's marriage or a dependent child's birth, adoption, or placement for adoption. Enrollment may be requested by calling the Boeing Service Center. To request enrollment for a new dependent more than sixty (60) days but within one hundred twenty (120) days after marriage, birth, adoption, or placement for adoption, the retired employee must call the Boeing Service Center and speak with a customer service representative. The retired employee must provide the Boeing Service Center with any required supporting documentation within thirty-one (31) days of the date the dependent enrollment change is requested or the coverage change request will be denied.

SECTION 4
EFFECTIVE DATE OF COVERAGE

A. Retired Employees

For newly retired employees, the Plan becomes effective on the first day of the month coinciding with the day such eligible employee retires, provided the retired employee pays any required contributions.

B. Dependents

The retired employee's current eligible dependents are covered automatically under the Plan on the same date the retired employee's coverage is effective, provided proper application is made and the retired employee pays any required contributions. Eligible dependents acquired after the retired employee's coverage is effective become covered on the date of marriage, date of birth, or date the child is legally placed with the retired employee for adoption, if application is made within one hundred twenty (120) days and the retired employee pays any required contributions. For other newly eligible dependents, coverage is effective on the date dependency is established, if application is made within sixty (60) days and the retired employee pays any required contributions.

SECTION 5
COMPANY AND RETIRED EMPLOYEE CONTRIBUTIONS

Company and retired employee contributions for the Retiree Medical Plan are described in Article 16 – Group Benefits.

If contributions are required and coverage is elected, the retired employee may authorize the monthly deduction of the applicable amount from his or her retirement check from The Boeing Company Employee Retirement Plan. Otherwise, the retired employee may arrange to self-pay for coverage through the Boeing Service Center.

SECTION 6
RETIREE MEDICAL PLAN

Medical plans and benefits offered to retirees and their eligible dependents are the same as those offered to active employees as described in Attachment A.

SECTION 7
TERMINATION OF COVERAGE

A. Retiree Coverage

Medical coverage for the retired employee terminates on the earliest of the following dates:

1. The end of the month before the month the retired employee attains age 65.
2. The end of the month before the month the retired employee becomes eligible for Medicare.
3. The end of the month before the month the retired employee becomes covered under another medical plan offered by or through the Company.
4. The end of the last month for which any required contributions are paid.

B. Dependent Coverage

Coverage for the eligible dependents of the retired employee terminates on the earliest of the following dates:

1. The end of the month the person no longer is an eligible dependent.
2. The end of the month before the month the person attains age 65.
3. The end of the month before the month the person becomes eligible for Medicare.
4. The end of the month in which the retired employee dies, if there is no surviving spouse.
5. The end of the month in which the retired employee's surviving spouse dies.
6. The end of the last month the retired employee is covered under this Retiree Medical Plan or the Company-sponsored Medicare Supplement Plan except in the case of the retired employee's death.
7. The end of the last month for which any required contributions are paid.

C. Continuation of Medical Coverage (COBRA)

If medical coverage for the retired employee's dependents otherwise would terminate due to one of the following reasons, these benefits may continue for specified periods under Public Law 99-272, Title X, as amended, if the individual makes a timely request to the Company and pays the required contribution:

1. The retired employee's death.

2. The retired employee's divorce.

3. The retired employee becomes entitled to Medicare.

4. A dependent child ceases to be a dependent as defined under this Plan. (A child eligible to be continued under the Plan's incapacitated child provision will still be considered to have dependent status.)

D. Conversion Privilege

If medical coverage terminates for reasons other than voluntary cancellation of coverage by the individual or by becoming eligible for another Company-sponsored plan, that individual may apply for an individual policy of insurance of a kind then being issued by the service representative for group conversion purposes. Evidence of good health will not be required, provided written application is made and the first retiree premium is paid within thirty-one (31) days following the end of the month in which medical coverage terminates. The individual's policy will be issued at the service representative's customary rate applicable to the age of the individual and to the form and amount of insurance provided under the converted policy.

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